

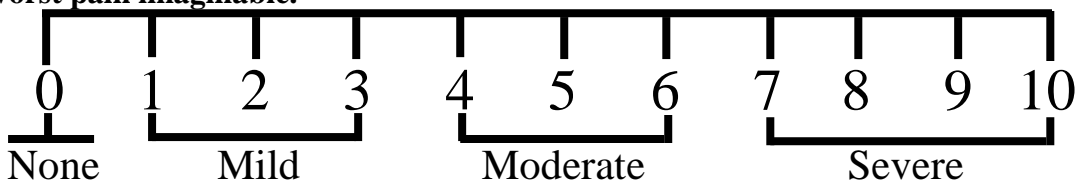
NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**NECK PAIN DISABILITY INDEX QUESTIONNAIRE**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p><b>SECTION 1 - Pain Intensity</b></p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6 - Concentration</b></p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p>
<p><b>SECTION 2 - Personal Care (Washing, Dressing, etc.)</b></p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self care.</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7 - Work</b></p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p>
<p><b>SECTION 3 - Lifting</b></p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p>	<p><b>SECTION 8 - Driving</b></p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car at all.</p>
<p><b>SECTION 4 - Reading</b></p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot read as much as I want because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p>	<p><b>SECTION 9 - Sleeping</b></p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours)</p>
<p><b>SECTION 5 - Headaches</b></p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p><b>SECTION 10 - Recreation</b></p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all of my recreational activities with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in a few of my recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreational activities because of pain in my neck.</p> <p><input type="checkbox"/> I cannot do any recreational activities at all.</p>

Please indicate the intensity of your neck pain over the past 24 hours on a scale of 0-10 where 0 is no pain and 10 is the worst pain imaginable.



## The Dizziness Handicap Inventory ( DHI )

P1. Does looking up increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E2. Because of your problem, do you feel frustrated?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F3. Because of your problem, do you restrict your travel for business or recreation?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P4. Does walking down the aisle of a supermarket increase your problems?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F7. Because of your problem, do you have difficulty reading?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E10. Because of your problem have you been embarrassed in front of others?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P11. Do quick movements of your head increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F12. Because of your problem, do you avoid heights?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P13. Does turning over in bed increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F16. Because of your problem, is it difficult for you to go for a walk by yourself?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P17. Does walking down a sidewalk increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E18. Because of your problem, is it difficult for you to concentrate	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No

E20. Because of your problem, are you afraid to stay home alone?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E21. Because of your problem, do you feel handicapped?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E22. Has the problem placed stress on your relationships with members of your family or friends?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
E23. Because of your problem, are you depressed?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
F24. Does your problem interfere with your job or household responsibilities?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No
P25. Does bending over increase your problem?	<input type="radio"/> Yes <input type="radio"/> Sometimes <input type="radio"/> No

Used with permission from GP Jacobson.

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990;116: 424-427

### DHI Scoring Instructions

The patient is asked to answer each question as it pertains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on disability.

To each item, the following scores can be assigned:

No=0 Sometimes=2 Yes=4

Scores:

Scores greater than 10 points should be referred to balance specialists for further evaluation.

16-34 Points (mild handicap)

36-52 Points (moderate handicap)

54+ Points (severe handicap)

# HEADACHE DISABILITY INDEX

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SCORES TOTAL: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
 (100) (52) (48)

**INSTRUCTIONS:** Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

**INSTRUCTIONS: PLEASE READ CAREFULLY:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my routine daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches			
F7. Because of my headaches I am less likely to socialize.			
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel a headache is starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of my headaches.			
E14. My headaches place stress on my relationships with family or friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### The Activities-specific Balance Confidence (ABC) Scale

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

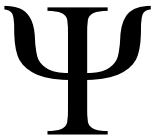
0% 10 20 30 40 50 60 70 80 90 100%

no confidence

completely confident

**“How confident are you that you will not lose your balance or become unsteady when you...**

1. ...walk around the house? \_\_\_\_\_%
2. ...walk up or down stairs? \_\_\_\_\_%
3. ...bend over and pick up a slipper from the front of a closet floor \_\_\_\_\_%
4. ...reach for a small can off a shelf at eye level? \_\_\_\_\_%
5. ...stand on your tiptoes and reach for something above your head? \_\_\_\_\_%
6. ...stand on a chair and reach for something? \_\_\_\_\_%
7. ...sweep the floor? \_\_\_\_\_%
8. ...walk outside the house to a car parked in the driveway? \_\_\_\_\_%
9. ...get into or out of a car? \_\_\_\_\_%
10. ...walk across a parking lot to the mall? \_\_\_\_\_%
11. ...walk up or down a ramp? \_\_\_\_\_%
12. ...walk in a crowded mall where people rapidly walk past you? \_\_\_\_\_%
13. ...are bumped into by people as you walk through the mall? \_\_\_\_\_%
14. ... step onto or off an escalator while you are holding onto a railing? \_\_\_\_\_%
15. ... step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? \_\_\_\_\_%
16. ...walk outside on icy sidewalks? \_\_\_\_\_%



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# PCS

Client No.:

Age:

Sex: M( ) F( )      Date:

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

**0** – not at all    **1** – to a slight degree    **2** – to a moderate degree    **3** – to a great degree    **4** – all the time

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### *When I'm in pain ...*

- 1      I worry all the time about whether the pain will end.
- 2      I feel I can't go on.
- 3      It's terrible and I think it's never going to get any better.
- 4      It's awful and I feel that it overwhelms me.
- 5      I feel I can't stand it anymore.
- 6      I become afraid that the pain will get worse.
  
- 7      I keep thinking of other painful events.
- 8      I anxiously want the pain to go away.
- 9      I can't seem to keep it out of my mind.
- 10     I keep thinking about how much it hurts.
- 11     I keep thinking about how badly I want the pain to stop.
- 12     There's nothing I can do to reduce the intensity of the pain.
- 13     I wonder whether something serious may happen.

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*...Total*