Neck Disability Index

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please answer based upon your average pain over the past two weeks **without pain medication.**

SECTION 1— Pain Intensity
0 □ I have no pain at the moment.
1 □ The pain is very mild at the moment.
2 □ The pain is moderate and comes and goes.
3 □ The pain is moderate and does not vary much.
4 □ The pain is severe but comes and goes.
5 □ The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing etc.)
0 □ I can look after myself without extra neck pain.
1 □ I can look after myself but it causes extra pain.
2 □ It is painful to look after myself and I am slow and careful.
3 □ I need some help, but manage most of my personal care.
4 □ I need help every day in most aspect of self-care.
5 □ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 – Lifting
0 □ I can lift heavy weights without extra pain.
1 □ I can lift heavy weights, but it causes extra neck pain.
2 □ Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently placed for example, on a table.
3 □ Pain prevents me from lifting heavy weights but I can lift light to medium weights if they are conveniently placed.
4 □ I can lift very light weights.
5 □ I cannot lift or carry anything at all due to neck pain.

SECTION 4 – Work
0 □ I can do as much work as I want to.
1 □ I can do my usual work but no more.
2 □ I can do most of my usual work but no more.
3 □ I cannot do my usual work.
4 □ I can hardly do work at all.
5 □ I cannot do any work.

SECTION 5 – Headache
0 □ I have no headaches at all.
1 □ I have slight headaches that come infrequently.
2 □ I have moderate headaches that come infrequently.
3 □ I have moderate headaches that come frequently.
4 □ I have severe headaches that come frequently.
5 □ I have headaches almost all of the time.

SECTION 6 – Concentration.
0 □ I can concentrate fully with no difficulty.
1 □ I can concentrate fully with slight difficulty.
2 □ I have a fair degree of difficulty in concentrating
3 □ I have a lot of difficulty in concentrating.
4 □ I have a great deal of difficulty in concentrating.
5 □ I cannot fully concentrate at all.

SECTION 7 – Sleeping
0 □ I have no trouble sleeping.
1 □ My sleep is slightly disturbed (less than 1 hour sleepless).
2 □ My sleep is mildly disturbed (1-2 hours sleepless).
3 □ My sleep is moderately disturbed (2-3 hours sleepless).
4 □ My sleep is greatly disturbed (3-5 hours sleepless).
5 □ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 8 – Driving
0 □ I can drive my car without neck pain.
1 □ I can drive my car as long as I want with slight neck pain.
2 □ I can drive my car as long as I want with moderate neck pain.
3 □ I cannot drive my car as long as I want because of moderate neck pain.
4 □ I can hardly drive my car at all because of severe neck pain.
5 □ I cannot drive my car at all.

SECTION 9- Reading
0 □ I can read as much as I want with no neck pain.
1 □ I can read as much as I want with slight neck pain.
2 □ I can read as much as I want with moderate neck pain.
3 □ I can't read as much as I want because of moderate neck pain.
4 □ I can't read as much as I want because of severe neck pain.
5 □ I can't read at all due to neck pain.

SECTION 10 – Recreation
0 □ I am able to engage in all recreational activities with no pain.
1 □ I am able to engage in all recreational activities with slight pain.
2 □ I am able to engage in most, but not all, recreational activities because of pain.
3 □ I am unable to engage in a few of my usual recreational activities because of pain.
4 □ I can hardly do any recreational activities because of neck pain.
5 □ I cannot do any recreational activities due to neck pain.

Signature:_____

Printed Name:_____

Date:_____

RATE YOUR PAIN ON A SCALE FROM 0-10

Score: %_____ **BMI:**_____

DOB: ____/____/____ **Age:**_____

ICD-9:_____ **Diagnosis:**_____

Level of Injection:_____ office use

IF YOU ARE POST-OP: (Please Circle)

1. Overall were you satisfied with your surgery? **YES NO**
2. If given the chance would you do the same surgery again? **YES NO**
3. Returned to work after surgery? **YES NO**
4. Retired? **YES NO**

Pre-Op 6 Week 3 Mon. 6 Mon. 1 Year 2 Year 3 Year 4 Year 5 Year