**SOUTHERN IDAHO THERAPY SERVICES**

Neck/Headache/Upper Back Functional Index

**Section 1: To be completed by patient**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days ago did onset/injury occur? \_\_\_\_\_\_

**Section 2: To be completed by patient**

This questionnaire has been designed to give your therapist information as to how your Neck/Headache/Upper Back has affected your ability to manage in everyday life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but ***please mark only the line which most closely describes your current condition.***

**WALKING**

🞏 Symptoms do not prevent me from walking any distance.

🞏 Symptoms prevent me walking more than 1 mile.

🞏 Symptoms prevent me walking more than ½ mile.

🞏 Symptoms prevent me walking more than ¼ mile.

🞏 I can only walk using a stick or crutches.

🞏 I am in bed most of the time and have to crawl to the toilet.

**WORK** *(Applies to work in home and outside)*

🞏 I can do as much work as I want to.

🞏 I can only do my usual work, but no more.

🞏 I can do most of my usual work, but no more.

🞏 I cannot do my usual work.

🞏 I can hardly do any work at all (only light duty).

🞏 I cannot do any work at all.

**PERSONAL CARE** *(Washing, Dressing, etc.)*

🞏 I can manage all personal care without symptoms.

🞏 I can manage all personal care with some increased symptoms

🞏 Personal care requires slow, concise movements due to increased symptoms.

🞏 I need help to manage some personal care.

🞏 I need help to manage all personal care.

🞏 I cannot manage any personal care.

**SLEEPING**

🞏 I have no trouble sleeping.

🞏 My sleep is mildly disturbed (less than 1 hour sleep loss).

🞏 My sleep is mildly disturbed (1-2 hours sleep loss).

🞏 My sleep is moderately disturbed (2-3 hours sleep loss).

🞏 My sleep is greatly disturbed (3-5 hours sleep loss).

🞏 My sleep is completely disturbed (6-7 hours sleep loss).

**RECREATION**

🞏 I am able to engage in all my recreational activities without increased symptoms.

🞏 I am able to engage in all my recreational activities with some increased symptoms.

🞏 I am able to engage in most, but not all of my usual recreational activities because of my increased symptoms.

🞏 I am able to engage in a few of my usual recreational activities because of my increased symptoms.

🞏 I can hardly do any recreational activities because of increased symptoms.

🞏 I cannot do any recreational activities at all.

**CONCENTRATION** Section 2 (continued) page 2

🞏 I can concentrate fully when I want to with no difficulty. Cervical/Thoracic

🞏 I can concentrate fully when I want to with slight difficulty.

🞏 I have a fair degree of difficulty in concentrating when I want to.

🞏 I have a lot of difficulty in concentrating when I want to.

🞏 I had a great deal of difficulty in concentrating when I want to.

🞏 I cannot concentrate at all.

**HEADACHES**

🞏 I have no headaches at all.

🞏 I have slight headaches which come less than 3 per week.

🞏 I have moderate headaches which come infrequently.

🞏 I have moderate headaches which come 4 or more per week.

🞏 I have severe headaches which come frequently.

🞏 I had headaches almost all of the time.

**READING**

🞏 I can read as much as I want without increased symptoms.

🞏 I can read as much as I want with slight symptoms.

🞏 I can read as much as I want with moderate symptoms.

🞏 I cannot read as much as I want because of moderate symptoms.

🞏 I can hardly read at all because of severe symptoms.

🞏 I cannot read at all.

**DRIVING**

🞏 I can drive my car or travel without any extra symptoms.

🞏 I can drive my car or travel as long as I want with slight symptoms.

🞏 I can drive my car or travel as long as I want with moderate symptoms.

🞏 I cannot drive my car or travel as long as I want because of moderate symptoms.

🞏 I can hardly drive at all or travel because of severe symptoms.

🞏 I cannot drive my car or travel at all.

**LIFTING**

🞏 I can lift heavy weights without extra symptoms.

🞏 I can lift heavy weights but it gives extra symptoms.

🞏 My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned.

🞏 My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are

conveniently positioned.

🞏 I can lift only very light weights.

🞏 I cannot lift or carry anything at all.

**Section 3: To be completed by patient**

**PAIN SCALE** – How severe is your pain? Circle the number that best describes your pain: 0 = No pain and 10 = worst imaginable

At its best? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Average? 0 1 2 3 4 5 6 7 8 9 10

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***Section 4: To be completed by physical therapist/provider***

SCORE: \_\_\_\_\_\_\_\_\_\_\_% Initial Evaluation

SCORE:\_\_\_\_\_\_\_\_\_\_\_% 10th Visit SCORE:\_\_\_\_\_\_\_\_\_\_\_\_% 20th Visit SCORE: \_\_\_\_\_\_\_\_\_\_% 30th Visit

SCORE:\_\_\_\_\_\_\_\_\_\_\_% Discharge

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