Patient Name: ____________________________________________________

In order to properly assess your condition and accurately grade your response to treatment, we must understand how much your neck and/or back problem(s) have affected your ability to manage everyday activities (ADLs).

For each section below, please circle the one number which most closely describes your condition right now.

### Pain Intensity:
- 0. No pain
- 1. Mild Pain
- 2. Moderate Pain
- 3. Severe Pain
- 4. Worst Possible Pain

### Pain Frequency:
- 0. No Pain
- 1. Occasional pain; 25% of the day
- 2. Intermittent pain; 50% of the day
- 3. Frequent pain; 75% of the day
- 4. Constant pain; 100% of the day

### Sleeping:
- 0. Perfect Sleep
- 1. Mildly Disturbed Sleep
- 2. Moderately Disturbed Sleep
- 3. Greatly disturbed sleep
- 4. Totally disturbed sleep

### Recreation:
- 0. Can do all activities
- 1. Can do most activities
- 2. Can do some activities
- 3. Can do few activities
- 4. Cannot do any activities

### Personal Care (washing, dressing, etc):
- 0. No pain; no restrictions
- 1. Mild pain; no restrictions
- 2. Moderate pain; need to go slowly
- 3. Moderate pain; need some assistance
- 4. Severe pain; need 100% assistance

### Lifting:
- 0. No pain with heavy weight
- 1. Increased pain with heavy weight
- 2. Increased pain with moderate weight
- 3. Increased pain with light weight
- 4. Increased pain with any weight

### Travel (driving, etc):
- 0. No pain on long trips
- 1. Mild pain on long trips
- 2. Moderate pain on long trips
- 3. Moderate pain on short trips
- 4. Severe pain on short trips

### Walking:
- 0. No pain; any distance
- 1. Increased pain after 1 mile
- 2. Increased pain after ½ mile
- 3. Increased pain after ¼ mile
- 4. Increased pain with all walking

### Work:
- 0. Can do usual plus unlimited extra work
- 1. Can do usual work; no extra work
- 2. Can do 50% of usual work
- 3. Can do 25% of usual work
- 4. Cannot work

### Standing:
- 0. No pain after several hours
- 1. Increased pain after several hours
- 2. Increased pain after 1 hour
- 3. Increased pain after ½ hour
- 4. Increased pain with any standing

Patient Signature: ______________________________________________ Date: _____________

Raw Score: _____________ Percent Impairment: _____________ Dr. Initials: ____________

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