

The Neck Pain Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section just one box that most applies to you. We realize you may consider two or more of these statements applicable to you, but mark the box that most closely describes how you feel.

SECTION 1—PAIN INTENSITY

- A. I have no pain at the moment
- B. The pain is very mild at the moment
- C. The pain is moderate at the moment
- D. The pain is fairly severe at the moment
- E. The pain is very severe at the moment
- F. The pain is the worst imaginable at the moment

SECTION 2—PERSONAL CARE

- A. I can look after myself without causing extra pain
- B. I can look after myself normally but it causes extra pain
- C. It is painful to look after myself and I am slow and careful
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self-care
- F. I do not get dressed; I wash with difficulty and stay in bed

SECTION 3—LIFTING

- A. I can lift heavy weights without extra pain
- B. I can lift heavy weights but it gives me extra pain
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex. on a table)
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- E. I can lift very light weights
- F. I cannot lift or carry anything at all

SECTION 4—READING

- A. I can read as much as I want to, with no pain in my neck
- B. I can read as much as I want to, with slight pain in my neck
- C. I can read as much as I want to, with moderate neck pain
- D. I can't read as much as I want due to moderate neck pain
- E. I can hardly read at all because of severe pain in my neck
- F. I cannot read at all because of neck pain

SECTION 5—HEADACHES

- A. I have no headaches at all
- B. I have slight headaches, which come infrequently
- C. I have moderate headaches, which come infrequently
- D. I have moderate headaches, which come frequently
- E. I have severe headaches, which come infrequently
- F. I have headaches almost all the time

SECTION 6—CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty
- B. I can concentrate fully when I want to with slight difficulty
- C. I have a fair degree of difficulty concentrating when I want to
- D. I have a lot of difficulty in concentrating when I want to
- E. I have a great deal of difficulty concentrating when I want to
- F. I cannot concentrate at all

SECTION 7—WORK

- A. I can do as much work as I want to
- B. I can only do my usual work, but no more
- C. I can do most of my usual work, but no more
- D. I cannot do my usual work
- E. I can hardly do any work at all
- F. I can't do any work at all

SECTION 8—DRIVING

- A. I can drive my car without any neck pain
- B. I can drive my car as long as I want with slight neck pain
- C. I can drive my car as long as I want with moderate neck pain
- D. I can't drive my car as long as I want due to moderate neck pain
- E. I can hardly drive at all due to severe pain in my neck
- F. I can't drive my car at all because of neck pain

SECTION 9—SLEEPING

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless)
- C. My sleep is mildly disturbed (1-2 hours sleepless)
- D. My sleep is moderately disturbed (2-3 hours sleepless)
- E. My sleep is greatly disturbed (3-5 hours sleepless)
- F. My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10—RECREATION

- A. I can engage in all my recreation activities with no neck pain
- B. I can engage in all my recreation activities with some neck pain
- C. I can engage in most, but not all, of my recreation activities due to neck pain
- D. I can engage in a few of my usual recreation activities due to neck pain
- E. I can hardly do any recreation activities because of neck pain
- F. I can't do any recreation activities at all

Pain Severity Scale:

Rate your usual level of pain today by checking one box on the following scale.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Excruciating Pain

PATIENT NAME: _____

DATE: _____

SCORE: _____ / _____ **Office use only**

Reference: