NECK DISABILITY INDEX

This questionnaire has been designed to give the therapist information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section** and mark in each section only **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which **MOST CLOSELY** describes your problem.

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 - Personal Care (Washing, Dressing, etc.)

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

Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 - Reading

- I can read as I want with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all from severe pain in my neck.
- I cannot read at all.

Section 5 - Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 - Concentration

- I can concentrate fully when I want with no difficulty.
- 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 have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7—Work

- 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.
- I can't do any work at all.

Section 8 - Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

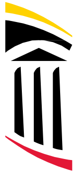
Signature:

____

Score: ______________________

Date: ______________________

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15



UNIVERSITY of MARYLAND
CHARLES REGIONAL
REHABILITATION

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Therapy Attendance Agreement

Welcome to Outpatient Physical Therapy at University of Maryland Charles Regional Rehabilitation. Our goal is to provide you with the best therapy services to reach your maximum potential and to improve your quality of life. We would like to inform you of our therapy attendance policy to ensure that you are getting the treatment that you need and other patients are not missing out on possible therapy times that they could have received.

Please read through and initial on the line that you have read and understand each statement:

____ CALL TO CANCEL OR RESCHEDULE. If you miss one therapy appointment without calling or cancelling at least 24 hours prior, you will be charged a $25 no show fee.

____ATTEND ALL YOUR APPOINTMENTS. If you miss three (3) consecutive therapy sessions and do not call, you will be discharged from therapy at the discretion of the therapist.

____ BE ON TIME. If you are more than 10 minutes late to a 30 minute appointment, it is up to the treating therapist if you will be seen that day.

____ If you have multiple cancellations, instances of tardiness, or missed appointments, it is up to the discretion of the primary therapist to discharge you from therapy.

All scheduling is on a first come, first served basis. We understand that both your schedule and our schedule can change and we will do our best to accommodate any changes that arise. Please inform us if you would like a copy of this form or if you have any questions about our appointment policy stated above.

Please sign that you understand and agree to the above policy:

________________________________ (Patient/Guardian) __________________ (Date & Time)

________________________________ (UM CRR Staff member) __________________ (Date & Time)

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Please answer all questions to the best of your knowledge

Do you have any known allergies (drugs, food, pollens, latex etc): ___________________________________

Have you had any falls in the last 12 months (please circle)? **Yes No**

How many falls? ____________ Did any fall result in injury? **Yes No**

Have you had any near falls? **Yes No** How many in the last 12 months? _______________

How do you learn best (please circle): **Reading Demonstration Pictures Listening**

Do you feel safe in your home (please circle)? **Yes No**

Are you being threatened or hurt by someone (please circle)? **Yes No**

Over the past 2 weeks, how often have you been bothered by any of the following problems (please circle)?

	Not At All	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
Little Interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

What is your preferred language? ___________________________________

Which language do you want to use while you are receiving services here? ___________________________

Do you have, or have you had, any of the following?

- ☐ Aids/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, Bronchitis, COPD, or Emphysema
- ☐ Cancer
- ☐ Cardiac History (Angina, Congenital Heart Disorder, Heart Attack, Pace Maker, Defibrillator, Palpitations, Irregular Heartbeat, Other)
- ☐ Dementia
- ☐ Diabetes
- ☐ Dizziness or Vertigo
- ☐ Edema
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Frequent Cough
- ☐ Gout
- ☐ Headaches or Migraines
- ☐ Hearing Difficulties or Ringing in your ears
- ☐ Hepatitis A, B or C
- ☐ High/Low Blood pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Loss or Cognitive Problems
- ☐ Nausea/Vomiting
- ☐ Orthopedic History
- ☐ Osteoporosis
- ☐ Pain
- ☐ Pregnant or Nursing
- ☐ Recent Weight loss
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Abnormalities
- ☐ Sleeping Difficulties
- ☐ Speech Problems
- ☐ Swallowing Problems
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vision Problems (Galucoma, Cataracts, Macular Degeneration, etc)
- ☐ Other ____________ ________________ ________________

Comments and details regarding above history (surgeries and medication on next page): _______________

____

Has the patient OR a sick close contact had international travel with in the last 30 days? **Yes No**

Where was the travel to and on what dates? ______________________________________

Does the patient currently have a fever OR flu-like symptoms? **Yes No**

(Symptoms include headache, aches, vomiting, abdominal pain, diarrhea, chills, etc)

University of Maryland
Charles Regional Medical Center
LaPlata, Maryland 20646

RS-027 (0816)

PATIENT LABEL

REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE

REHABILITATION SERVICES – AMBULATORY SUMMARY LIST

Major Surgeries	**Date**	**Current Medication**	**Dosage**	**Frequency**

(Please ask for surgery/medication form if more space is needed)

Therapist Review – Office Use only

Have you previously participated in physical/occupational/speech therapy? **Yes** **No**

Have you had therapy services this calendar year? **Yes** **No**

Were you treated for your current diagnosis or another diagnosis? **Current** **Different**

Have you had any recent imaging performed (please circle)?

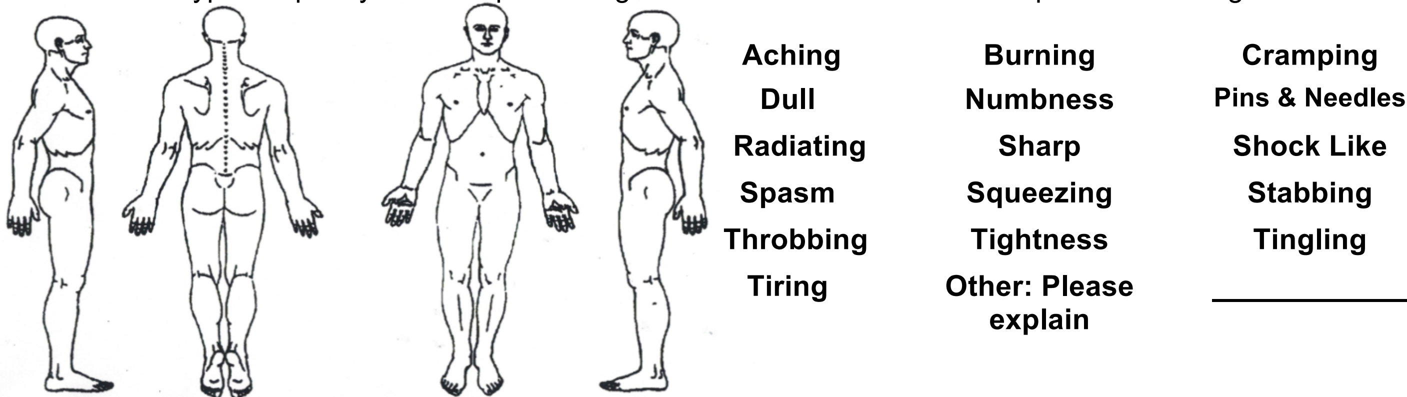
X-ray **CT scan** **MRI** **EMG** **Modified Barium Swallow** **Other**

Do you have any restrictions from activity from your doctor? **Yes** **No**

If yes, please explain: ______________________________

What are your goals for therapy? ______________________________

Please circle types of pain you are experiencing and draw or shade in areas of pain on the diagram:



Aching	**Burning**	**Cramping**
Dull	**Numbness**	**Pins & Needles**
Radiating	**Sharp**	**Shock Like**
Spasm	**Squeezing**	**Stabbing**
Throbbing	**Tightness**	**Tingling**
Tiring	**Other: Please explain**	____________

Advanced Directives: ☐ Durable Power of Attorney ☐ Living Will ☐ Organ Donor ☐ DNR ☐ N/A

Patients Name (Please write legibly): ______________________________

Signature of Patient: ______________________________ Date: ____________

Signature of Caregiver (if under 18 or assisting in filling out form): ______________________________

Signature of Therapist: ______________________________ Date: ____________

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REHABILITATION SERVICES – OUTPATIENT MEDICAL QUESTIONNAIRE

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