Neck Pain and Disability Scale

Last First Middle Initial Month Day Year ID Number Chart Number Examiner's Initials PLEASE MAKE AN "X" ALONG THE LINE TO SHOW HOW FAR FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOUR PAIN PROBLEM HAS TAKEN YOU SCORE 1. How bad is your pain today? O 5 NO PAIN	Name			/	
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O	2. How bad is you	r pain on average?			
3. How bad is your pain at its worst? O	•		5		
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NO PAIN CANNOT TOLERATE 4. Does your pain interfere with your sleep? O	3. How bad is you	r pain at its worst?			
4. Does your pain interfere with your sleep? O	0 _		_ 5	5	
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NOT AT ALL S. How bad is your pain with standing? O	4. Does your pain	interfere with your	sleep?		
5. How bad is your pain with standing? O	0		_ 5		
NO PAIN MOST SEVERE PAIN 6. How bad is your pain with walking? O	NOT AT ALL		CAN'T SLEE	P	
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11. Does your pain interfere with personal care (eating, dressing, bathing, etc.)? 0 5 5					_
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NOT AT ALL					

12. Does your pain interfere with	personal relationships (family, friends, sex, etc.)?
0	5
NOT AT ALL	ALWAYS
13. How has your pain changed y	our outlook on life and the future (depression, hopelessness)?
0	5
NO CHANGE	COMPLETELY CHANGED
14. Does pain affect your emotion	as?
0	5
NOT AT ALL	COMPLETELY
15. Does your pain affect your ab	ility to think or concentrate?
0	5
NOT AT ALL	COMPLETELY
16. How stiff is your neck?	
0	5
NOT STIFF	CAN'T MOVE NECK
17. How much trouble so you have	e turning your neck?
0	5
NO TROUBLE	CAN'T MOVE NECK
18. How much trouble do you hav	ve looking up and down?
0	5
NO TROUBLE	CAN'T LOOK UP OR DOWN
19. How much trouble do you hav	ve working overhead?
0	5
NO TROUBLE	CAN'T WORK OVERHEAD
20. How much do pain pills help?	
0	5
COMPLETE RELIEF	NO RELIEF
	TOTAL SCORE
AGEOCCUF	PATION