

Low Back Disability Index



Name:

Date:

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in a section may apply but please just select one statement per section.

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

- I can look after myself normally without 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 everyday 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 causing extra pain
- I can lift heavy weights, but it gives me extra pain.
- I can lift heavy weights if they are conveniently positioned
- I can sometimes lift heavy weights but mostly light weights
- I can only lift very light weights
- I cannot lift or carry anything at all

Section 4 - Walking

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/2 miles
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5 - Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6 - Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want with extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 30 minutes
- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Section 7 - Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed for less than 1 hour
- My sleep is mildly disturbed for up to 1-2 hours
- My sleep is moderately disturbed for up to 2-3 hours
- My sleep is greatly disturbed for up to 3-5 hours
- My sleep is completely disturbed for up to 5-7 hours

Section 8 - Sex Life (If applicable)

- My sex life is normal and causes no pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 - Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases pain
- My social life is normal but I limit physical activities
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life due to pain

Section 10 - Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to necessary journeys under 30 minutes
- Pain prevents me from traveling except to appointments

Office Use

Score:

Neck Disability Index



Name:

Date:

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present day situation.

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 6 - Concentration

- I can concentrate fully without difficulty
- I can concentrate fully with slight difficulty
- I have a fair degree of difficulty concentrating
- I have a lot of difficulty concentrating
- I have a great deal of difficulty concentrating
- I can't concentrate at all

Section 2 - Personal Care

- I can look after myself normally without 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 everyday in most aspects of self care
- I do not get dressed, I wash with difficulty and stay in bed

Section 7 - Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed for less than 1 hour
- My sleep is mildly disturbed for up to 1-2 hours
- My sleep is moderately disturbed for up to 2-3 hours
- My sleep is greatly disturbed for up to 3-5 hours
- My sleep is completely disturbed for up to 5-7 hours

Section 3 - Lifting

- I can lift heavy weights without causing extra pain
- I can lift heavy weights, but it gives me extra pain.
- I can lift heavy weights if they are conveniently positioned
- I can sometimes lift heavy weights but mostly light weights
- I can only lift very light weights
- I cannot lift or carry anything at all

Section 8 - Driving

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

Section 4 - Work

- I can do as much work as I want
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I can't do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 9 - Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want due to moderate neck pain
- I can't read as much as I want due to severe neck pain
- I can't read at all

Section 5 - Headaches

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

Section 10 - Recreation

- I have no neck pain during all recreational activities
- I have some neck pain with all recreational activities
- I have some neck pain with a few recreational activities
- I have neck pain with most recreational activities
- I can hardly do recreational activities due to neck pain
- I can't do any recreational activities due to neck pain

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Score:

Arm, Shoulder, and Hand Disability Index



Name: _____

Date: _____

Please rate your ability to do the following activities in the last week by writing a number in the white box that best represents the difficulty of each activity.

1 No difficulty	2 Mild difficulty	3 Moderate difficulty	4 Severe difficulty	5 Unable
1. Open a tight or new jar <input type="text"/>		2. Write <input type="text"/>		3. Turn a key <input type="text"/>
4. Prepare a meal <input type="text"/>		5. Push open a heavy door <input type="text"/>		6. Place an object on a shelf above your head <input type="text"/>
7. Do heavy household chores (e.g., wash walls, wash floors) <input type="text"/>		8. Garden or do yard work <input type="text"/>		9. Make a bed <input type="text"/>
10. Carry a shopping bag or briefcase <input type="text"/>		11. Carry a heavy object (over 10 lbs) <input type="text"/>		12. Change a lightbulb overhead <input type="text"/>
13. Wash or blow dry your hair <input type="text"/>		14. Wash your back <input type="text"/>		15. Put on a pullover sweater <input type="text"/>
16. Use a knife to cut food <input type="text"/>		17. Activities that require little effort (knitting, cardplaying, etc.) <input type="text"/>		18. Activities that require some force (golf, hammering, tennis, etc.) <input type="text"/>
		19. Activities that require movement (frisbee, badminton, etc.) <input type="text"/>		20. Manage transportation needs (driving, etc.) <input type="text"/>

Turn page for more questions

22. To what extent has your arm, shoulder, or hand problem interfered with your social activities?

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

23. Were you limited in your work or other regular daily activities as a result of an arm, shoulder, or hand problem?

1	2	3	4	5
Not limited	Slightly Limited	Moderately limited	Agree	Strongly agree

24. How much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?

1	2	3	4	5
No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	So much difficulty

25. I feel less capable, less confident, or less useful because of my arm, shoulder, or hand problem.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Please use the scale below to rate the following questions

1	2	3	4	5
None	Mild	Moderate	Severe	Extreme

24. Arm, shoulder, or hand pain

25. Arm, shoulder, or any hand pain when performed any specific activity

26. Tingling (pins and needles) in your arm, shoulder, or hand

25. Weakness in your arm, shoulder, or hand

27. Stiffness in your arm, shoulder, or hand

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Dash Disability/Symptom Score =

[(Sum of n responses / n) -1] x 25, where n is the number of completed responses.

A dash score may not be calculated if there are greater than 3 missing items.

The Lower Extremity Disability Index



Name: _____

Date: _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking medical attention. Please rate your ability to do the following activities in the last week by **writing a number in the white box** that best represents the difficulty of each activity.

0 Extreme difficulty or unable to perform activity	1 Quite a bit of difficulty	2 Moderate difficulty	3 A little bit of difficulty	4 No difficulty
1. Any of your usual work, housework, or school activities <input type="text"/>	2. Your usual hobbies, recreational or sporting activities <input type="text"/>	3. Getting into or out of the bath / shower <input type="text"/>		
4. Walking from room to room <input type="text"/>	5. Putting on your shoes or socks <input type="text"/>	6. Squatting <input type="text"/>		
7. Lifting an object, like a bag of groceries from the floor. <input type="text"/>	8. Performing light activities around your home <input type="text"/>	9. Performing heavy activities around your home <input type="text"/>		
10. Getting into or out of a car <input type="text"/>	11. Walking 2 blocks <input type="text"/>	12. Walking a mile <input type="text"/>		
13. Going up or down a flight of stairs <input type="text"/>	14. Standing for 1 hour <input type="text"/>	15. Sitting for 1 hour <input type="text"/>		
16. Running on even ground <input type="text"/>	17. Running on uneven ground <input type="text"/>	18. Making sharp turns while walking or running <input type="text"/>		
19. Hopping / jumping <input type="text"/>		20. Rolling over in bed <input type="text"/>		

Reprinted from Binkley, J., Stratford, P., Loft, S., Riddle, D., & The North American Orthopedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale developed, measurement properties, and clinical application, Physical Therapy.

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Score = /80

Minimum level of detectable change (90% Confidence): 9 points