

Functional Rating Index

Patient Name: _____

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

<p>1. Pain Intensity</p> <ul style="list-style-type: none">A. No painB. Mild PainC. Moderate PainD. Severe PainE. Worst Possible Pain	<p>2. Sleeping</p> <ul style="list-style-type: none">A. Perfect SleepB. Mildly disturbedC. Moderately DisturbedD. Greatly DisturbedE. Totally Disturbed
<p>3. Personal Care (washing, dressing, etc.)</p> <ul style="list-style-type: none">A. No pain; no restrictionB. Mild pain; no restrictionC. Moderate pain; need to go slowD. Moderate pain; need some assistanceE. Severe pain; 100% assistance	<p>4. Traveling (driving, etc.)</p> <ul style="list-style-type: none">A. No pain on long tripsB. Mild pain on long tripsC. Moderate pain on long tripsD. Moderate pain on short tripsE. Severe pain on short trips
<p>5. Working</p> <ul style="list-style-type: none">A. Can do usual work plus unlimited extraB. Can do usual work; no extraC. Can do 50% of usual workD. Can do 25% of usual workE. Cannot work	<p>6. Recreation</p> <ul style="list-style-type: none">A. Can do all activitiesB. Can do most activitiesC. Can do some activitiesD. Can do few activitiesE. Cannot do any activities
<p>7. Frequency of Pain</p> <ul style="list-style-type: none">A. No painB. Occasional pain; 25% of dayC. Intermittent pain; 50% of dayD. Frequent pain; 75% of dayE. Constant pain; 100% of day	<p>8. Lifting</p> <ul style="list-style-type: none">A. No pain with heavy liftingB. Increased pain with heavy liftingC. Increased pain with moderate weightD. Increased pain with light weightE. Increased pain with any weight
<p>9. Walking</p> <ul style="list-style-type: none">A. No pain any distanceB. Increased pain after 1 mileC. Increased pain after 1/2 mileD. Increased pain after 1/4 mileE. Increased pain with all walking	<p>10. Standing</p> <ul style="list-style-type: none">A. No pain after several hoursB. Increased pain after several hoursC. Increased pain after 1 hourD. Increased pain after 1/2 hourE. Increased pain with any standing

Patient Signature: _____

Date: _____

Doctor Signature: _____