Cardiff and Vale Spinal Unit
Mr M J H McCarthy FRCS

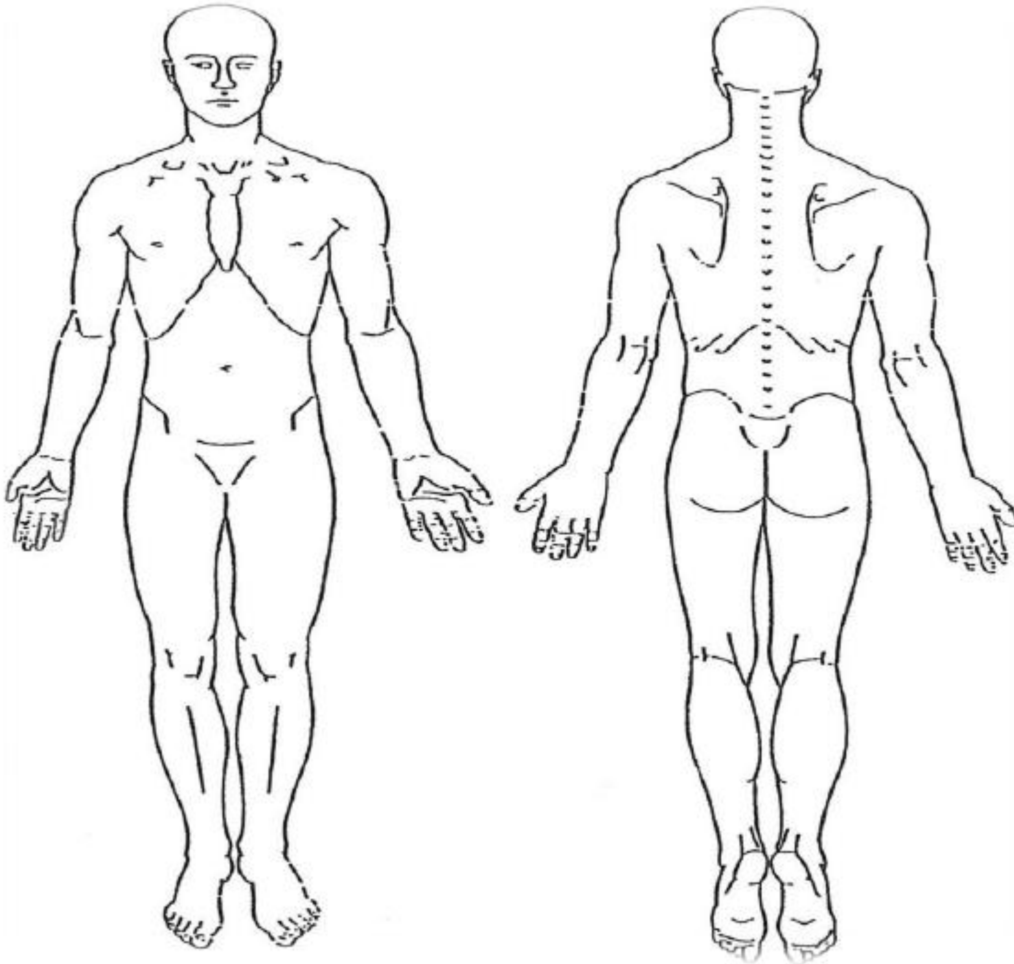
NECK / ARM PAIN QUESTIONNAIRE

Affix Patient Label

This document contains a series of standard assessments that are very useful in helping us assess your spinal problem. The questions also help to determine whether or not there has been any benefit from the treatments you have received.

Todays Date:

Where is your pain located? Please shade the problem areas on the diagram and mark the worst affected area.



Please mark a point on the line between the faces to indicate how much **NECK PAIN** you have felt **OVER THE LAST MONTH**.

____

No pain **Worst pain ever**

Please mark a point on the line between the faces to indicate how much **ARM PAIN** you have felt **OVER THE LAST MONTH.**

____

No pain **Worst pain ever**

PLEASE ANSWER BY CIRCLING THE WORDS THAT BEST FIT YOUR PROBLEM.

Which pain is the worse pain? NECK PAIN ARM PAIN

How long have you had your present pain? Less than 7 weeks 7-12 weeks More than 12 weeks

Has it worsened over time? YES NO

Do you feel unsteady on your feet? YES NO

How far can you walk before you have to stop?
100 yards 200 yards 400 yards 800 yards 1 mile or more

Are you experiencing any numbness, weakness or tingling? YES NO

What triggered your pain?
Accident at work Following an illness Accident at Home

Following Surgery Car Accident Pain just began

Other:

Have you had previous spine surgery? YES NO

How does the pain affect your sleep?
Trouble falling asleep Medications needed to fall asleep Awakened by pain

The following is a list of things that may improve or worsen your pain. Please check the appropriate box as it affects your pain.

Improves		Worsens
	Movement	
	No movement	
	Rest / Sleep	
	Massage	
	Mild Exercise	

Improves		Worsens
	Medication	
	Walking	
	Sitting	
	Standing	
	Lying down	

What is your current status? E.g. Student, housewife, working, retired, disabled

……………………………………………………………………………

How much time have you lost from work in the last year?
None less than a week one to three weeks
three to six weeks six to twelve weeks three to six months
six to twelve months more than one year

Are you receiving disability Benefit? YES NO

Is there any personal injury claim pending regarding your back pain? YES NO

Have you had to retire because of your back? YES NO

Neck Disability Index (NDI)

Could you please complete this questionnaire? It is designed to give us information as to how your neck (or arm) trouble has affected your ability to manage in everyday life. Please answer every section. Mark **ONE** box only in each section that **most closely describes you over the last month**.

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 – Work** ☐ I can do as much work as I want to. ☐ I can 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 2 – Personal Care (washing, dressing, etc.) ☐ I can look after myself without causing extra pain. ☐ I can look after myself normally but it is very painful. ☐ 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, wash with difficulty and stay in bed.	**Section 7 – Concentration** ☐ I can concentrate fully when I want to 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 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 I can manage if they are conveniently positioned, e.g. on a table. ☐ Pain prevents me from lifting heavy weights, but I can mange light to medium weights if they are conveniently positioned. ☐ I can lift only very light weights. ☐ I cannot lift or carry anything at all.	**Section 8 – Driving (if applicable)** ☐ I can 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 neck pain. ☐ I can't drive my car as long as I want because of moderate pain in my neck. ☐ I can hardly drive at all because of severe pain in my neck ☐ I can't drive my car at all.
Section 4 – Reading ☐ I can read as much as I want to 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 to with moderate pain in my neck. ☐ I can't read as much as I want because of moderate pain in my neck. ☐ I can hardly read at all because of severe pain in my neck. ☐ I cannot read at all.	**Section 9 – Sleeping** ☐ I have no trouble sleeping. ☐ My sleep is slightly disturbed (less than 1 hour). ☐ My sleep is mildly distrubed (1-2 hrs sleepless). ☐ My sleep is moderately distrubed (2-3 hrs sleepless). ☐ My sleep is greatly distrubed (3-5 hrs sleepless). ☐ My sleep is completely distrurbed (5-7 hrs sleepless).
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 of the time.	**Section 10 – Recreation** ☐ I am able to engage in all my recreational activities with no neck pain at all. ☐ I am able to engage in all of my recreational activities with some neck pain. ☐ I am able to engage in most but not all of my usual recreation activities beacsue of pain in my neck. ☐ I am able to engage in few of my recreational activities beacsue of pain in my neck. ☐ I can hardly do any recreational activities because of pain in my neck. ☐ I can't do any recreational activities at all.

PHQ-9

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things................	0	1	2	3
2. Feeling down, depressed, or hopeless..................	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much..	0	1	2	3
4. Feeling tired or having little energy......................	0	1	2	3
5. Poor appetite or overeating..................................	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down......	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television...................	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual............................	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way............................	0	1	2	3

(*For office coding: Total Score* _____ = ___ + ___ + ___)

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

This section is for post operative patients only

Please mark a point on the line below to indicate how much you think your pain improved following your original operation. The far left end indicates complete pain relief (the operation worked very well) and the far right end indicates no pain relief (the operation did not help your pain).

Neck Pain

Complete Pain Relief **No Pain Relief**

Arm Pain

Complete Pain Relief **No Pain Relief**

How far can you walk?

100 yards 200 yards 400 yards 800 yards 1 mile or more

How would you rate your overall outcome from surgery?

Good Fair Poor

Would you have the operation again?

Yes No Not applicable

Please rate your % improvement in neck pain following the operation

<25 26-75 >76

Please rate your % improvement in arm pain following the operation

<25 26-75 >76

Are your daily activities restricted because of your neck / arm pain?

Yes great Yes some Not restricted

How much pain medication do you require for your neck / arm?

Regular As required None

Did you return to employment / work?

No Yes Limited Yes Full Not applicable

Thank you for your time completing this questionnaire.