

Functional Rating Index

For use with Neck and/or Back Problems

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, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0-----1-----2-----3-----4
 No pain Mild pain Moderate pain Severe pain Worst possible pain

2. Sleeping

0-----1-----2-----3-----4
 Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0-----1-----2-----3-----4
 No pain; no restrictions Mild pain; no restrictions Moderate pain; need to go slowly Moderate pain; need some assistance Severe pain; need 100% assistance

4. Travel (driving, etc.)

0-----1-----2-----3-----4
 No pain on long trips Mild pain on long trips Moderate pain on long trips Moderate pain on short trips Severe pain on short trips

5. Work

0-----1-----2-----3-----4
 Can do usual work plus unlimited extra work Can do usual work no extra work Can do 50% of usual work Can do 25% of usual work Cannot work

6. Recreation

0-----1-----2-----3-----4
 Can do all activities Can do most activities Can do some activities Can do a few activities Cannot do any activities

7. Frequency of pain

0-----1-----2-----3-----4
 No pain Occasional pain; 25% of the day Intermittent pain; 50% of the day Frequent pain; 75% of the day Constant pain; 100% of the day

8. Lifting

0-----1-----2-----3-----4
 No pain with heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight

9. Walking

0-----1-----2-----3-----4
 No pain; any distance Increased pain after 1 mile Increased pain after ½ mile Increased pain after ¼ mile Increased pain with all walking

10. Standing

0-----1-----2-----3-----4
 No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after ½ hour Increased pain with any standing

(Printed) Name: _____

Signature: _____

Date: _____

Total Score: _____