Name: ____________________ Date: __________

Phone: ____________________ Date of Birth: __________

Shoulder Disability Index

Initial

Instructions: The following 15 questions relate to daily experiences. Please mark an X in only **ONE** of the boxes opposite each question. The middle box can be used if you occasionally have problems with the activity.

	Yes	Can Give Problems	No
1. I wake up at night because of shoulder pain.	❑	❑	❑
2. My shoulder hurts when I lie on it.	❑	❑	❑
3. It is difficult to put on a coat or sweater because of shoulder pain.	❑	❑	❑
4. My shoulder hurts during my usual daily activities.	❑	❑	❑
5. My shoulder hurts when I lean on my elbow or hand.	❑	❑	❑
6. My shoulder hurts when I move my arm.	❑	❑	❑
7. My shoulder hurts when I write or type.	❑	❑	❑
8. My shoulder hurts when I hold the driving wheel of my car or handle bars of my bike.	❑	❑	❑
9. When I lift and carry something my shoulder hurts.	❑	❑	❑
10. During reaching and grasping something above shoulder level my shoulder hurts.	❑	❑	❑

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SHOULDER DISABILITY INDEX

	YES	CAN GIVE PROBLEMS	NO
11. My shoulder is painful whenever I open or close a door.	❑	❑	❑
12. My shoulder is painful when I bring my hand to the back of my head.	❑	❑	❑
13. My shoulder is painful when I bring my hand to my buttock.	❑	❑	❑
14. I rub my painful shoulder more than once a day.	❑	❑	❑
15. Because of shoulder pain I am more irritable and bad tempered with people than usual.	❑	❑	❑

___ 30

SHOULDER PAIN

Circle only one number on each line.

Do you suffer from shoulder pain **at the moment?**

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** shoulder pain been, which you have experienced in the last two weeks?

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your shoulder pain within the last two weeks?

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

___ 30

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SHOULDER DISABILITY INDEX

MEDICATION

Please mark an X in only **ONE** of the boxes

1. I am not taking any medication because of pain. ☐
2. I take non-prescription medication occasionally (once or twice a week) ☐
3. I take non-prescription medication daily (four to five days a week) ☐
4. I take prescription medication occasionally (once or twice a week) ☐
5. I take prescription medication daily (four to five days a week) ☐

PATIENT'S OWN ASSESSMENT

Please mark an X in only **ONE** of the boxes

1. I am basically healthy and without symptoms. ☐
2. I manage a normal existance but am occasionally disturbed by shoulder symptoms. ☐
3. I can manage my job but am frequently disturbed by shoulder symptoms. ☐
4. I am considerably bothered by shoulder symptoms which influence both work and liesure time. ☐
5. I am completely disabled by shoulder trouble. ☐

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SHOULDER DISABILITY INDEX

RESERVED FOR THE DOCTOR

DOCTOR'S CLINICAL IMPRESSION:

1. Basically healthy and without symptoms. ☐
2. Manages a normal existance but is occasionally disturbed by shoulder symptoms. ☐
3. Is capable of work but is frequently disturbed by shoulder symptoms ☐
4. Is considerably bothered by shoulder symptoms which influence both work and leisure time. ☐
5. Disabled by shoulder trouble. ☐

Range of Motion:

	R.	L.
Abd / (Add)		

	R.	L.
Flex / Ext.		

Buttock ☐
Lumbar ☐
Thoracic ☐

	R.	L.
IR / ER		

Shoulder Strength:

	R	L
Flex		
Ext.		
Abd		
(Add)		
IR		
ER		

Comments: ______________________________

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Name: ______________________________ Date: ______________

Phone: ______________________________ Date of Birth: ______________________

THE ROLAND-MORRIS DISABILITY QUESTIONNAIRE

INITIAL

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain. When you read them, you may find that some stand out because they describe you today. As you read the following list, think of yourself today. When you read a sentence that describes you today, put a tick against it. If the sentence does not describe you then leave the space blank and go on to the next one. Remember, only tick the sentence if you are sure that it describes you today.

- ☐ 1. I stay at home most of the time because of my back.
- ☐ 2. I change position frequently to try and get my back comfortable.
- ☐ 3. I walk more slowly than usual because of my back.
- ☐ 4. Because of my back, I am not doing any of the jobs that I usually do around the house.
- ☐ 5. Because of my back, I use a handrail to get upstairs.
- ☐ 6. Because of my back, I lie down to rest more often.
- ☐ 7. Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ 8. Because of my back, I try to get other people to do things for me.
- ☐ 9. I get dressed more slowly than usual because of my back.
- ☐ 10. I only stand for short periods of time because of my back.
- ☐ 11. Because of my back, I try not to bend or kneel down.
- ☐ 12. I find it difficult to get out of a chair because of my back.
- ☐ 13. My back is painful almost all the time.
- ☐ 14. I find it difficult to turn over in bed because of my back.
- ☐ 15. My appetite is not very good because of my back pain.
- ☐ 16. I have trouble putting on my socks (or stockings) because of the pain in my back.
- ☐ 17. I only walk short distances because of my back.
- ☐ 18. I sleep less well on my back.
- ☐ 19. Because of my back pain, I get dressed with help from someone else.
- ☐ 20. I sit down for most of the day because of my back.
- ☐ 21. I avoid heavy jobs around the house because of my back.
- ☐ 22. Because of my back pain, I am more irritable and bad tempered with people than usual.
- ☐ 23. Because of my back, I go upstairs more slowly than usual.
- ☐ 24. I stay in bed most of the time because of my back.

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THE ROLAND-MORRIS DISABILITY QUESTIONNAIRE

LOW BACK PAIN

Back Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from low back pain **at the moment?**

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** low back pain been, which you have experienced in the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your low back pain within the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

LEG PAIN

30

Leg Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from leg pain **at the moment?**

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** leg pain been, which you have experienced in the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your leg pain within the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

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The Roland-Morris Disability Questionnaire

Medication

Please mark an X in only ONE of the boxes

1. I am not taking any medication because of pain. ☐
2. I take non-prescription medication occasionally (once or twice a week) ☐
3. I take non-prescription medication daily (four to five days a week) ☐
4. I take prescription medication occasionally (once or twice a week) ☐
5. I take prescription medication daily (four to five days a week) ☐

Patient's Own Assessment

Please mark an X in only ONE of the boxes

1. I am basically healthy and without symptoms. ☐
2. I manage a normal existance but am occasionally bothered by back trouble. ☐
3. I can manage my job but am frequently bothered by back symptoms. ☐
4. I am considerably bothered by back symptoms both at work and in my spare time. ☐
5. I am incapable of work. ☐

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THE ROLAND-MORRIS DISABILITY QUESTIONNAIRE

RESERVED FOR THE DOCTOR

DOCTOR'S CLINICAL IMPRESSION:

1. Basically healthy and without symptoms. ☐
2. Manages a normal existance but is occasionally bothered by symptoms of back illness. ☐
3. Is capable of work but is frequently bothered by back illness. ☐
4. Is considerably bothered by back symptoms both at work and in spare time. ☐
5. Is incapable of work. ☐

Endurance Test: Static Extensor (Sorensen's) ____________________
McKenzie Test ☐ +ve ☐ -ve

Strength Test: ____________________

R.O.M.-Modified Schoeber's Test: F = 15cm - Xcm E = 15cm - Xcm RLF:
= = LLF:

Range of Motion:
TLF.
– SF. ____________________ RLF.
= F. Ext. LLF.

Balance:	R	L	B	Squat:	Sit up:
EO.					
EC.				Comments:	

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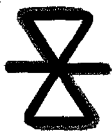

Name: ______________________ Date: ______________

Phone: ______________________ Date of Birth: ______________

WHIPLASH DISABILITY INDEX

INITIAL:

Instructions: The following 20 questions relate to daily experiences. Please mark an X in only **ONE** of the boxes opposite each question. The middle box can be used if you occasionally have problems with the activity.

		YES	CAN GIVE PROBLEMS	NO
1.	Do you have difficulties sleeping through the night due to symptoms from your whiplash accident?	☐	☐	☐
2.	Can you manage daily activities since your whiplash accident?	☐	☐	☐
3.	Can you manage daily activities without help from others?	☐	☐	☐
4.	Can you manage putting on your clothes in the morning without taking more time than usual?	☐	☐	☐
5.	Can you bend over the washing basin in order to brush your teeth without experiencing symptoms?	☐	☐	☐
6.	Do you spend more time than usual at home since your accident?	☐	☐	☐
7.	Do you have problems lifting objects weighing from 2 - 4 kg.?	☐	☐	☐
8.	Have you reduced your reading activity since the accident?	☐	☐	☐
9.	Have you been bothered by headaches since the accident?	☐	☐	☐
10.	Have you been bothered by dizziness since the accident?	☐	☐	☐
11.	Have you been bothered by "ringing in the ears" since the accident?	☐	☐	☐
12.	Have you experienced periods of extreme tiredness since the accident?	☐	☐	☐
13.	Do you feel that your ability to concentrate has been reduced since the accident?	☐	☐	☐
14.	Have you experienced visual disturbances since the accident?	☐	☐	☐

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WHIPLASH DISABILITY INDEX

	YES	CAN GIVE PROBLEMS	NO
15. Have you experienced pain to other parts of your spine (low back, or between the shoulder blades) since the accident?	❑	❑	❑
16. Are you prevented from participating in usual leisure time activities due to symptoms from the accident?	❑	❑	❑
17. Do you remain in bed longer than usual since the accident?	❑	❑	❑
18. Do you feel that your whiplash symptoms have influenced your emotional relationship with your nearest family?	❑	❑	❑
19. Have you had to give up social contact with other people during the past two weeks because of symptoms related to the accident?	❑	❑	❑
20. Do you feel that symptoms from the accident will influence your future?	❑	❑	❑

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NECK PAIN

Neck Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from neck pain **at the moment?**

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** neck pain been, which you have experienced in the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your neck pain within the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

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WHIPLASH DISABILITY INDEX

ARM PAIN

Arm Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from arm pain **at the moment?**

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** arm pain been, which you have experienced in the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your arm pain within the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

___ /30

MEDICATION

Please mark an X in only ONE of the boxes

1. I am not taking any medication because of pain. ☐
2. I take non-prescription medication occasionally (once or twice a week) ☐
3. I take non-prescription medication daily (four to five days a week) ☐
4. I take prescription medication occasionally (once or twice a week) ☐
5. I take prescription medication daily (four to five days a week) ☐

PATIENT'S OWN ASSESSMENT

Please mark an X in only ONE of the boxes

1. I am basically healthy and without symptoms. ☐
2. I manage a normal existance but am occasionally bothered by neck trouble. ☐
3. I can manage my job but am frequently bothered by neck symptoms. ☐
4. I am considerably bothered by neck symptoms both at work and in my spare time. ☐
5. I am incapable of work. ☐

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Whiplash Disability Index

Reserved for the Doctor

Doctor's Clinical Impression:

1. Basically healthy and without symptoms. ☐
2. Manages a normal existance but is occasionally bothered by symptoms of neck illness. ☐
3. Is capable of work but is frequently bothered by neck illness. ☐
4. Is considerably bothered by neck symptoms both at work and in spare time. ☐
5. Is incapable of work. ☐

Endurance Test: ______________________

Strength Test: FLEX. ______________________
EXT.

Range of Motion: FLEX. __________ RR. __________ RLF. __________
EXT. LR. LLF.

Initial Training Dosage: ______________________

Dynomometer: R | L

Comments: ______________________

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Name: ______________________ Date: ______________

Phone: ______________________ Date of Birth: ______________

NECK - SHOULDER DISABILITY INDEX

INITIAL

Instructions: The following 15 questions relate to daily experiences. Please mark an X in only **ONE** of the boxes opposite each question. The middle box can be used if you occasionally have problems with the activity.

	YES	CAN GIVE PROBLEMS	NO
1. Can you sleep through the night without neck pain interfering with your rest?	❑	❑	❑
2. Can you manage your job without neck pain being a problem?	❑	❑	❑
3. Can you manage daily activities without help from others?	❑	❑	❑
4. Can you put on your clothes without having to take extra time because of neck pain?	❑	❑	❑
5. Can you bend over your bathroom sink in the morning to brush your teeth without neck pain interfering?	❑	❑	❑
6. Do you stay home more due to neck pain?	❑	❑	❑
7. Do you have problems lifting small objects weighing from 2 - 4 kg. because of neck pain?	❑	❑	❑
8. Have you reduced your reading because of neck pain?	❑	❑	❑
9. Have you been bothered by headaches during the time that you have had neck pain?	❑	❑	❑

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NECK - SHOULDER DISABILITY INDEX

	YES	CAN GIVE PROBLEMS	NO
10. Has your ability to concentrate been reduced by neck pain?	❑	❑	❑
11. Are you prohibited from partaking in your usual spare time activities because of neck pain?	❑	❑	❑
12. Do you remain in bed longer than usual due to neck pain?	❑	❑	❑
13. Have you had to give up social contact with people during the last two weeks because of neck pain?	❑	❑	❑
14. Do you think there are certain jobs that you would not be able to manage because of neck pain?	❑	❑	❑
15. Do you think that neck pain will influence your future?	❑	❑	❑

NECK PAIN

___ 30

Neck Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from neck pain **at the moment?**

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** neck pain been, which you have experienced in the last two weeks?

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your neck pain within the last two weeks?

No Pain At All *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

___ 30

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NECK - SHOULDER DISABILITY INDEX

ARM PAIN

Arm Pain during the past 14 days. **Mark only one number on each line.**

Do you suffer from arm pain **at the moment?**

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

How painful has the **worst** arm pain been, which you have experienced in the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

The **average** level of your arm pain within the last two weeks?

No Pain At All — *Worst Possible Pain*

0 1 2 3 4 5 6 7 8 9 10

____ 30

Please mark an X in only ONE of the boxes

MEDICATION

1. I am not taking any medication because of pain. ☐
2. I take non-prescription medication occasionally (once or twice a week) ☐
3. I take non-prescription medication daily (four to five days a week) ☐
4. I take prescription medication occasionally (once or twice a week) ☐
5. I take prescription medication daily (four to five days a week) ☐

Please mark an X in only ONE of the boxes

PATIENT'S OWN ASSESSMENT

1. I am basically healthy and without symptoms. ☐
2. I manage a normal existance but am occasionally bothered by neck trouble. ☐
3. I can manage my job but am frequently bothered by neck symptoms. ☐
4. I am considerably bothered by neck symptoms both at work and in my spare time. ☐
5. I am incapable of work. ☐

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NECK - SHOULDER DISABILITY INDEX

RESERVED FOR THE DOCTOR

DOCTOR'S CLINICAL IMPRESSION:

1. Basically healthy and without symptoms. ☐
2. Manages a normal existance but is occasionally bothered by symptoms of neck illness. ☐
3. Is capable of work but is frequently bothered by neck illness. ☐
4. Is considerably bothered by neck symptoms both at work and in spare time. ☐
5. Is incapable of work. ☐

Endurance Test: ______________________________

Strength Test: FLEX. ______________________________
EXT.

Range of Motion: FLEX. __________ RR. __________ RLF. __________
EXT. LR. LLF.

Initial Training Dosage: ______________________________

Dynomometer: R | L

Comments: ______________________________

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