Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Patient Name_____ Date _____

Activities-specific Balance Confidence (ABC) Scale

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100%
no confidence ... completely confident

"How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes and reach for something above your head? ____%
6. …stand on a chair and reach for something? ____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? ____%
10. …walk across a parking lot to the mall? ____%
11. …walk up or down a ramp? ____%
12. …walk in a crowded mall where people rapidly walk past you? ____%
13. …are bumped into by people as you walk through the mall?____%
14. … step onto or off an escalator while you are holding a railing? ____%
15. … step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. …walk outside on icy sidewalks? ____%

Dizziness Handicap Inventory

Patient: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question. Answer each question as it pertains to your dizziness or unsteadiness only.

Item	Question		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yardwork?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around your house in the dark?	F			
20	Because of your problem, are you afraid to stay home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationships with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
	Totals				

Patient Name: _____ Date: _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

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 attention. Please provide an answer for each activity. ***Today, do you or would you have any difficulty at all with:***

	Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a bit of difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
1	Any of your usual work housework or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Getting into or out of bath	0	1	2	3	4
4	Walking between rooms	0	1	2	3	4
5	Putting on your shoes or socks	0	1	2	3	4
6	Squatting	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8	Performing light activities around your home	0	1	2	3	4
9	Performing heavy activities around your home	0	1	2	3	4
10	Getting into our out of a car	0	1	2	3	4
11	Walking 2 blocks	0	1	2	3	4
12	Walking 1 mile	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs	0	1	2	3	4
14	Standing for one hour	0	1	2	3	4
15	Sitting for one hour	0	1	2	3	4
16	Running on even ground	0	1	2	3	4
17	Running on uneven ground	0	1	2	3	4
18	Making sharp turns while running fast	0	1	2	3	4
19	Hopping	0	1	2	3	4
20	Rolling over in bed	0	1	2	3	4
	Column Totals					

Score: _____/80

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Upper Extremity Index Please Circle Number

		No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1.	Open a tight or new jar	1	2	3	4	5
2.	Write	1	2	3	4	5
3.	Turn a key	1	2	3	4	5
4.	Prepare a Meal	1	2	3	4	5
5.	Push open a heavy door	1	2	3	4	5
6.	Place an object on a shelf above your head	1	2	3	4	5
7.	Do heavy household chores (e.g wash walls, wash floors	1	2	3	4	5
8.	Button your clothes	1	2	3	4	5
9.	Make a bed	1	2	3	4	5
10.	Carry a shopping bag or briefcase	1	2	3	4	5
11.	Carry a heavy object (over 10lbs)	1	2	3	4	5
12.	Change a light bulb overhead	1	2	3	4	5
13.	Wash or blow dry your hair	1	2	3	4	5
14.	Wash your back	1	2	3	4	5
15.	Put on a pullover sweater	1	2	3	4	5
16.	Use a knife to cut food	1	2	3	4	5
17.	Garden or do yard work	1	2	3	4	5
18.	Recreational activities that require little effort (card playing, knitting)	1	2	3	4	5
19.	Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g. hammering, tennis, golf)	1	2	3	4	5
20.	Recreational activities in which you move your hand freely (e.g. playing frisbee, badminton, etc)	1	2	3	4	5
21.	Manage transportation needs (getting from one place to another	1	2	3	4	5
		Not at All	**Slightly**	**Moderately**	**Quite a bit**	**Extremely**
22.	During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors	1	2	3	4	5
		Not Limited at all	**Slightly Limited**	**Moderately Limited**	**Very Limited**	**Unable**
23.	During the past week, were you limited in your work or other regular daily activities as a result of your am, shoulder or hand problem.	1	2	3	4	5
		None	**Mild**	**Moderate**	**Severe**	**Extreme**
24	Arm, Shoulder, Hand Pain	1	2	3	4	5
25	Arm Shoulder or hand pain when you performed any specific activity	1	2	3	4	5
26	Tingling (pins & needles) in your arm, shoulder or hand	1	2	3	4	5
27	Weakness in our arm, shoulder or hand	1	2	3	4	5
28	Stiffness in your arm, shoulder or hand	1	2	3	4	5
		No difficulty	**Mild difficulty**	**Moderate Difficulty**	**Severe Difficulty**	**Cannot Sleep**
29.	During the past week, how much difficulty have you had sleeping because of pain in your arm.	1	2	3	4	5
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly agree**
30.	I fell less capable, less confident or less useful because of pain in your arm, shoulder or hand	1	2	3	4	5

Patient Name: _____ Date: _____

Score: _____ (| (sum of n responses/n)-1 | x 25 where n is the number of completed responses. Must have minimum of 27 responses

Name _____ DOB _____

Date of Injury _____ Date_____

Post Concussion Symptom Scale

No symptoms"0"-------Moderate "3"---------Severe"6"

Time after Concussion

SYMPTOMS	Days/Hrs _____	Days/Hrs _____	Days/Hrs _____
Headache	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Trouble falling to sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Excessive sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Loss of sleep	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Light sensitivity	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Noise sensitivity	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Irritability	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Sadness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Nervousness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
More emotional	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Numbness	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling "slow"	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Feeling "foggy"	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
Visual problems	0 1 2 3 4 5 6	0 1 2 3 4 5 6	0 1 2 3 4 5 6
TOTAL SCORE	_____	_____	_____

Use of the Post-Concussion Symptom Scale: The athlete should fill out the form, on his or her own, in order to give a subjective value for each symptom. This form can be used with each encounter to track the athlete's progress towards the resolution of symptoms. Many athletes may have some of these reported symptoms at a baseline, such as concentration difficulties in the patient with attention-deficit disorder or sadness in an athlete with underlying depression, and must be taken into consideration when interpreting the score. Athletes do not have to be at a total score of zero to return to play if they already have had some symptoms prior to their concussion.

Score:

MODIFIED GAIT EFFICACY SCALE

How much confidence do you have that you would be able to safely walk on a level surface such as a hardwood floor?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to walk safely on grass?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you be able to safely walk over an obstacle in your path?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to safely step down from a curb?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to safely step up onto a curb?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to walk up stairs if you are holding onto a railing?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to walk safely down stairs if you are holding onto a railing?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to safely walk up stairs if you are NOT holding onto a railing

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to safely walk down stairs if you are NOT holding onto a railing?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

How much confidence do you have that you would be able to safely walk a long distance such as ½ mile?

1	2	3	4	5	6	7	8	9	10

No confidence — complete confidence

Patient Name _____ DOB _____ Date_____