



Patient _____

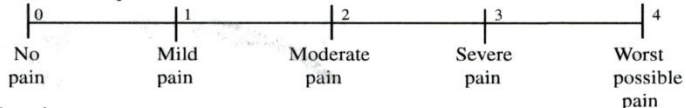
Date _____

Functional Rating Index

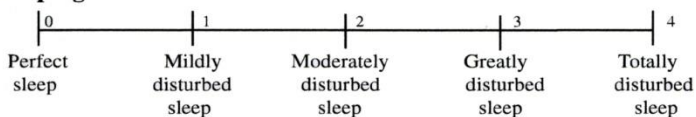
For use with Neck and/or Back Problems only.

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.

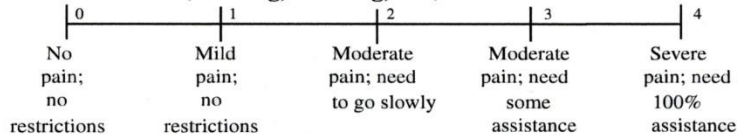
1. Pain Intensity



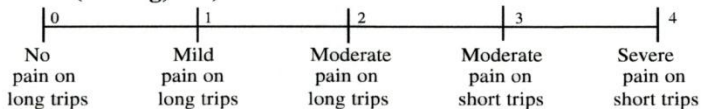
2. Sleeping



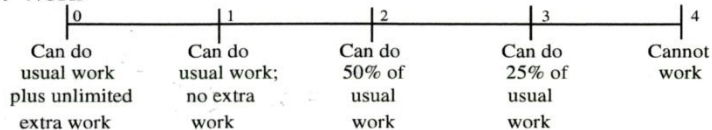
3. Personal Care (washing, dressing, etc.)



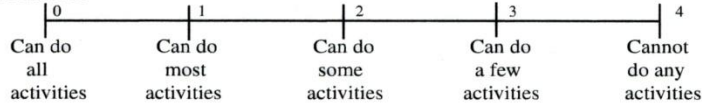
4. Travel (driving, etc.)



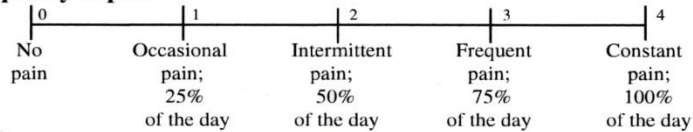
5. Work



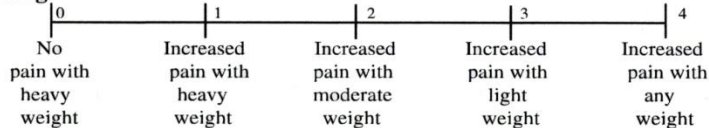
6. Recreation



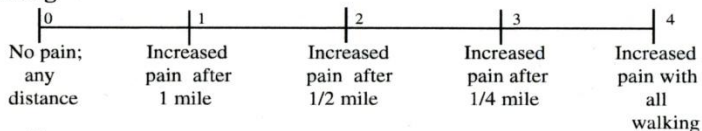
7. Frequency of pain



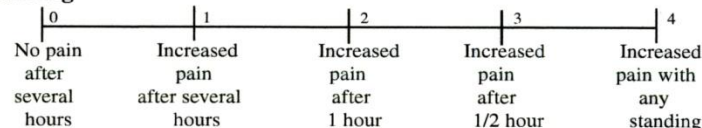
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Total Score _____

Date _____

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FOR DOCTORS USE ONLY

BP _____ Height _____ Weight (L) _____ (R) _____ = TOTAL _____

	ROM	PAIN
Cervical		
Thoracic		
Lumbar		