



MOTOR VEHICLE COLLISION PAIN CHART

Please take a moment to fill out this Pain Chart prior to your visit. All information is kept completely CONFIDENTIAL and will go directly to your chart for the practitioner to view.

Name _____ Today's Date _____

(DD / MM / YYYY)

Date of Birth: _____ Alberta Health Number: _____
(DD / MM / YYYY)

=====

Is this collision work-related or part of a WCB claim? ☐ NO ☐ YES Date of injury _____
(DD / MM / YYYY)

Area(s) of Concern: _____

What is the WORST pain you have ever experienced? (other than the pain you are experiencing NOW!)

What was the date of this painful experience _____?
(DD / MM / YYYY)

Rate this PAST pain you experienced

0 1 2 3 4 5 6 7 8 9 10
No Severe
Pain Pain

The LIMITATION I am having NOW is

- ☐ Grade 0: No pain or discomfort, Mild uneasiness may/may not be present, Activities are not interfered with
- ☐ Grade 1: Minimal discomfort to mild pain, Pain/discomfort is an annoyance, Activities are normal but I have concern for certain motions or postures
- ☐ Grade 2: Slight pain to moderate pain, Pain has a marked presence, Pain reduces activities
- ☐ Grade 3: Moderate pain to severe pain, Pain is so imposing as to change my lifestyle, Pain dictates activities
- ☐ Grade 4: Severe pain to very severe pain, Pain is so overwhelming with little relief, Only activity is in seeking relief
- ☐ Grade 5: Pain can vary from moderate to severe, Pain has been long standing (6 months or more), Pain has only at times been interrupted by treatment, Considerable time and effort is spent searching for relief from pain

Rate this OVERALL PAIN you are experiencing NOW.

0	1	2	3	4	5	6	7	8	9	10
No										Severe
Pain										Pain

Rate the most COMMON/AVERAGE intensity of your pain complaint.

0	1	2	3	4	5	6	7	8	9	10
No										Severe
Pain										Pain

Rate the severity of pain at the ONSET (beginning) of your complaint.

0	1	2	3	4	5	6	7	8	9	10
No										Severe
Pain										Pain

NECK PAIN & DISABILITY QUESTIONNAIRE (VERNON-MIOR)

This questionnaire has been designed to give the doctor information as to how your NECK PAIN has affected your ability to manage everyday life. Please answer EVERY section, marking only ONE box which applies to you. We realize that you may consider that two of the statements in any one section relate to you but please just mark the box which most closely describes your problem RECENTLY.

1. Neck Pain: INTENSITY

- ☐ 0 - I have no pain at the moment
- ☐ 1 - The pain is very mild at the moment
- ☐ 2 - The pain is moderate at the moment
- ☐ 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

2. Neck Pain: PERSONAL CARE (Washing, Dressing, etc.)

- ☐ 0 - I can look after myself normally without causing extra pain
- ☐ 1 - I can look after myself normally but it causes extra pain
- ☐ 2 - I can look after myself normally but it causes extra pain
- ☐ 3 - I need some help but 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

3. Neck Pain: 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 - I can manage light to moderate weights at the most
- ☐ 4 - I can only lift very light weights if they are conveniently positioned (e.g. on a table)
- ☐ 5 - I cannot lift or carry anything at all

4. Neck Pain: READING

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

5. Neck Pain: 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

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NECK PAIN & DISABILITY QUESTIONNAIRE (VERNON-MIOR) (Cont'd)**6. Neck Pain: CONCENTRATION**

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

7. Neck Pain: DRIVING

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

8. Neck Pain: RECREATION

- ☐ 0 - I am able to engage in all my recreational activities with no neck pain
☐ 1 - I am able to engage in all my recreational activities with some pain in my neck
☐ 2 - I am able to engage in most, but not all, of my usual recreational activity because of pain in my neck
☐ 3 - I am able to engage in only a few of my usual recreational activities because of pain in my neck
☐ 4 - I can hardly do any recreational activities because of pain in my neck
☐ 5 - I cannot do any recreational activities at all

9. Neck Pain: SLEEPING

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

10. Neck Pain: WORK

- ☐ 0 - I can do as much work as I want to
☐ 1 - I can only do my usual work but more
☐ 2 - I can 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

Rate your USUAL level of NECK PAIN

0	1	2	3	4	5	6	7	8	9	10
No										Severe
Pain										Pain

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HEADACHE DISABILITY INDEX**Since my injury, I have a headache:**

☐ Once per month ☐ More than 1 but less than 4 per month ☐ More than 1 per week

My headache is:

☐ Mild ☐ Moderate ☐ Severe

The purpose of the scale is to identify difficulties that you may be experiencing because of your HEADACHE.

Please read carefully.

Please check 1 response per line.

Answer each question as it pertains to your HEADACHE only.

Because of my headaches, I feel handicapped	☐ NO	☐ Sometimes	☐ YES
Because of my headaches, I feel restricted in my routine daily activities	☐ NO	☐ Sometimes	☐ YES
No one understands the effect my headaches have on my life	☐ NO	☐ Sometimes	☐ YES
I restrict my recreational activities (e.g. sports, hobbies) because of my headaches	☐ NO	☐ Sometimes	☐ YES
My headaches still make me angry	☐ NO	☐ Sometimes	☐ YES
I still feel that I am going to lose control because of my headaches	☐ NO	☐ Sometimes	☐ YES
Because of my headaches I am less likely to socialize	☐ NO	☐ Sometimes	☐ YES
My spouse/significant other, family or friends have no idea what I am going through because of my headaches	☐ NO	☐ Sometimes	☐ YES
My headaches are so bad that I feel that I am going to go insane.	☐ NO	☐ Sometimes	☐ YES
My outlook on the world is affected by my headaches	☐ NO	☐ Sometimes	☐ YES
I am afraid to go outside when I feel that a headache is starting	☐ NO	☐ Sometimes	☐ YES
I feel desperate because of my headaches	☐ NO	☐ Sometimes	☐ YES
I am concerned that I am paying penalties at work or at home because of my headaches	☐ NO	☐ Sometimes	☐ YES
My headaches place stress on my relationships with family or friends	☐ NO	☐ Sometimes	☐ YES
I avoid being around people when I have a headache	☐ NO	☐ Sometimes	☐ YES
I believe my headaches are making it difficult for me to achieve my goals in life	☐ NO	☐ Sometimes	☐ YES
I am unable to think clearly because of my headaches	☐ NO	☐ Sometimes	☐ YES
I get tense (e.g. muscle tension) because of my headaches	☐ NO	☐ Sometimes	☐ YES
I do not enjoy social gatherings because of my headaches	☐ NO	☐ Sometimes	☐ YES
I feel irritable because of my headaches	☐ NO	☐ Sometimes	☐ YES
I avoid travelling because of my headaches	☐ NO	☐ Sometimes	☐ YES
My headaches make me feel confused	☐ NO	☐ Sometimes	☐ YES
My headaches make me feel frustrated	☐ NO	☐ Sometimes	☐ YES
I find it difficult to read because of my headaches	☐ NO	☐ Sometimes	☐ YES
I find it difficult to focus my attention away from my headaches and on other things	☐ NO	☐ Sometimes	☐ YES

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LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

This questionnaire has been designed to give the doctor information as to how your BACK PAIN has affected your ability to manage in everyday life.

Please answer EVERY section, marking only ONE box which applies to you.

We realize that you may consider that two of the statements in any one section relate to you but please just mark the box which most closely describes your problem RECENTLY.

1. Low Back Pain: 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 moderate and does not vary much
- ☐ 4 - The pain comes and goes and is very severe
- ☐ 5 - The pain is severe and does not vary much

2. Low Back Pain: PERSONAL CARE (Washing, Dressing, etc.)

- ☐ 0 - I can look after myself without extra pain
- ☐ 1 - I can look after myself normally but it causes extra pain
- ☐ 2 - Looking after myself increases the pain but I manage not to change my way of doing it
- ☐ 3 - Looking after myself increases the pain and I find it necessary to change my way of doing it
- ☐ 4 - I am unable to look after myself without some help because of the pain
- ☐ 5 - I am unable to do any personal care without help because of the pain

3. Low Back Pain: 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 - I can manage light to moderate weights at the most
- ☐ 4 - I can only lift very light weights if they are conveniently positioned (e.g. on a table)
- ☐ 5 - I cannot lift or carry anything at all

4. Low Back Pain: WALKING

- ☐ 0 - I have no pain when walking
- ☐ 1 - I have some pain when walking but it does not increase with distance
- ☐ 2 - I cannot walk more than 1 km without increasing pain
- ☐ 3 - I cannot walk more than 1/2 km without increasing pain
- ☐ 4 - I cannot walk more than 1/4 km without increasing pain
- ☐ 5 - I cannot walk at all without increasing pain

5. Low Back Pain: SITTING

- ☐ 0 - I can sit in any chair for as long as I like
- ☐ 1 - I can only sit in my favourite chair for 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 straight away

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LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry) (Cont'd)**6. Low Back Pain: STANDING**

- ☐ 0 - I can stand as long as I want without pain
- ☐ 1 - I have some pain on standing but it doesn't increase with time
- ☐ 2 - I can't stand for longer than one hour without increasing pain
- ☐ 3 - I can't stand for longer than 1/2 hour without increasing pain
- ☐ 4 - I can't stand for longer than 10 minutes without pain
- ☐ 5 - I avoid standing because it increases the pain right away

7. Low Back Pain: TRAVELLING

- ☐ 0 - I get no pain whilst travelling
- ☐ 1 - I get some pain whilst travelling but none of my usual forms of travel make it any worse
- ☐ 2 - I get extra pain whilst travelling but it does not compel me to seek alternate forms of travel
- ☐ 3 - I get extra pain whilst travelling which compels me to seek alternate forms of travel
- ☐ 4 - Pain prevents all forms of travel except if laying down
- ☐ 5 - Pain prevents all forms of travel

8. Low Back Pain: SOCIAL LIFE

- ☐ 0 - My social life is normal and gives me no pain
- ☐ 1 - My social life is normal but increases the degree of pain
- ☐ 2 - Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing
- ☐ 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 pain

9. Low Back Pain: SLEEPING

- ☐ 0 - I get no pain in bed
- ☐ 1 - I get pain in bed but it does not prevent me from sleeping well
- ☐ 2 - My normal night's sleep is reduced by 25% or less because of pain
- ☐ 3 - My normal night's sleep is reduced by 50% or less because of pain
- ☐ 4 - My normal night's sleep is reduced by 75% or less because of pain
- ☐ 5 - Pain prevents me from sleeping at all

10. Low Back 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 nor worse
- ☐ 4 - My pain is gradually worsening
- ☐ 5 - My pain is rapidly worsening

Rate your USUAL level of LOW BACK PAIN

0	1	2	3	4	5	6	7	8	9	10
No Pain										Severe Pain

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LOW BACK PAIN DISABILITY QUESTIONNAIRE (Roland-Morris)

LOW BACK pain may make it more difficult to do some things that you normally do.

Please read carefully.

Answer each question as it describes your LOW BACK pain CURRENTLY (within the last week).

Because of my back pain, I stay at home most of the time	☐ NO	☐ YES
I change position frequently to try and get my back comfortable	☐ NO	☐ YES
Because of my back pain, I walk more slowly than usual	☐ NO	☐ YES
Because of my back pain, I am not doing any jobs that I usually do around the house	☐ NO	☐ YES
Because of my back pain, I use a handrail to get upstairs	☐ NO	☐ YES
Because of my back pain, I lie down to rest more often	☐ NO	☐ YES
Because of my back pain, I have to hold on to something to get out of an easy chair	☐ NO	☐ YES
Because of my back pain, I try to get other people to do things for me	☐ NO	☐ YES
Because of my back pain, I get dressed more slowly than usual	☐ NO	☐ YES
Because of my back pain, I only stand up for short periods of time	☐ NO	☐ YES
Because of my back pain, I try not to bend or kneel down	☐ NO	☐ YES
Because of my back pain, I find it difficult to get out of a chair	☐ NO	☐ YES
My back is painful almost all of the time	☐ NO	☐ YES
Because of my back pain, I find it difficult to turn over in bed	☐ NO	☐ YES
Because of my back pain, my appetite is not very good	☐ NO	☐ YES
Because of my back pain, I have trouble putting on my socks (or stockings)	☐ NO	☐ YES
Because of my back pain, I only walk short distances	☐ NO	☐ YES
Because of my back pain, I don't sleep as well	☐ NO	☐ YES
Because of my back pain, I get dressed with help from someone else	☐ NO	☐ YES
Because of my back pain, I sit down for most of the day	☐ NO	☐ YES
Because of my back pain, I avoid heavy jobs around the house	☐ NO	☐ YES
Because of my back pain, I am more irritable and bad tempered with people than usual	☐ NO	☐ YES
Because of my back pain, I go upstairs more slowly than usual	☐ NO	☐ YES
Because of my back pain, I stay in bed most of the time	☐ NO	☐ YES

Rate your LOW BACK PAIN as you are experiencing it TODAY

0	1	2	3	4	5	6	7	8	9	10
No Pain										Severe Pain

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. - Required

Signature: _____ Date: _____

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