

Patient Name: _____

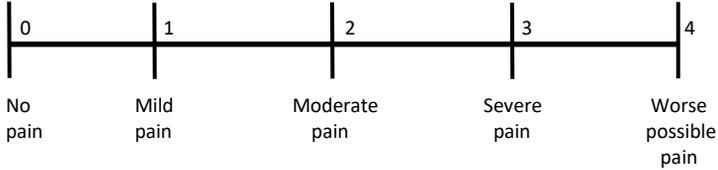
Date: _____

Functional Rating Index

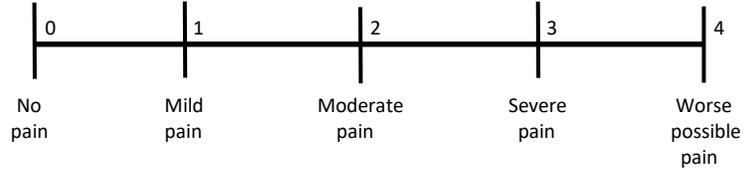
For use with Neck and/or Back problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

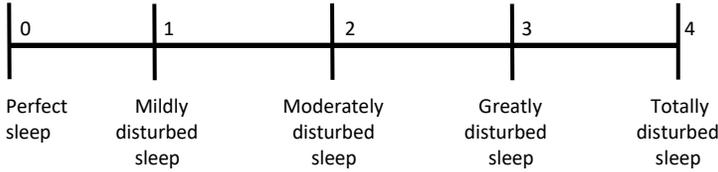
1. Pain Intensity



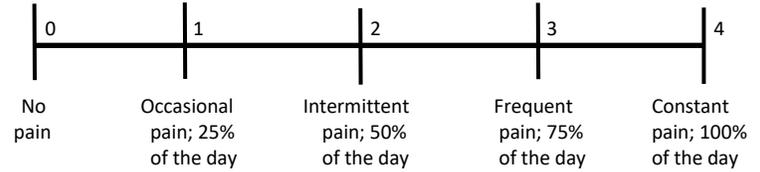
6. Recreation



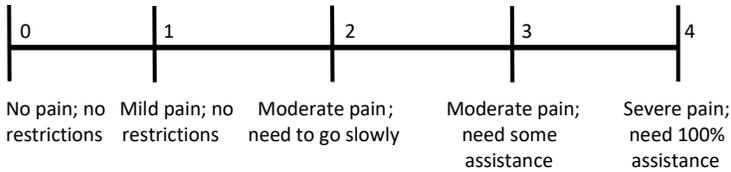
2. Sleeping



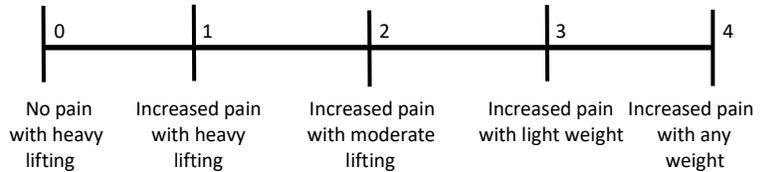
7. Frequency of Pain



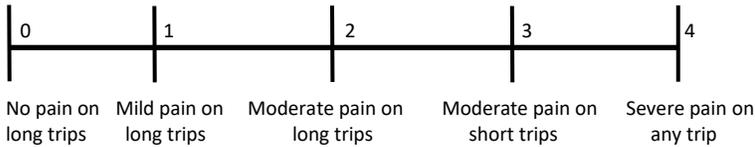
3. Personal Care (washing, dressing, etc.)



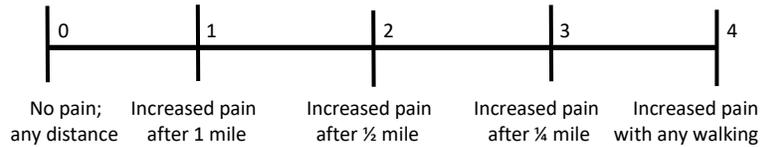
8. Lifting



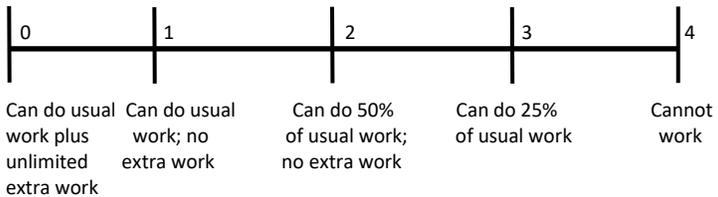
4. Traveling (driving, etc.)



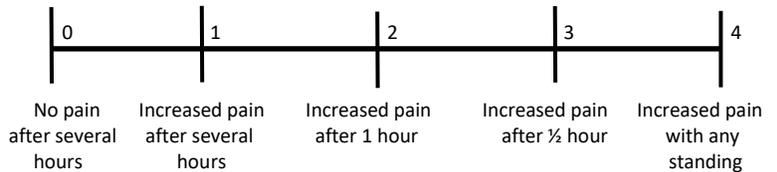
9. Walking



5. Work



10. Standing



Patient's Signature

Date

For Office Use Only:

Practitioner ID #: _____

Clinical Diagnosis Codes:

Patient ID #: _____

Total Score: _____ / 40

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CHIROPRACTOR

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