

## Copenhagen Neck Disability Scale

	Yes	Occasionally	No
1. Can you sleep at night without neck pain interfering?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can you manage daily activities without neck pain reducing activity levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can you manage daily activities without help from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you manage putting on your clothes in the morning without taking more time than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Can you bend over the washing basin in order to brush your teeth without getting neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you spend more time than usual at home because of neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you prevented from lifting objects weighing from 2-4kg due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you reduced your reading activity due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been bothered by headaches during the time that you have had neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel that your ability to concentrate is reduced due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you prevented from participating in your usual leisure time activities due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you remain in bed longer than usual due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you feel that neck pain has influenced your emotional relationship with your nearest family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had to give up social contact with other people during the past two weeks due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you feel that neck pain will influence your future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NAME \_\_\_\_\_

DATE \_\_\_\_\_