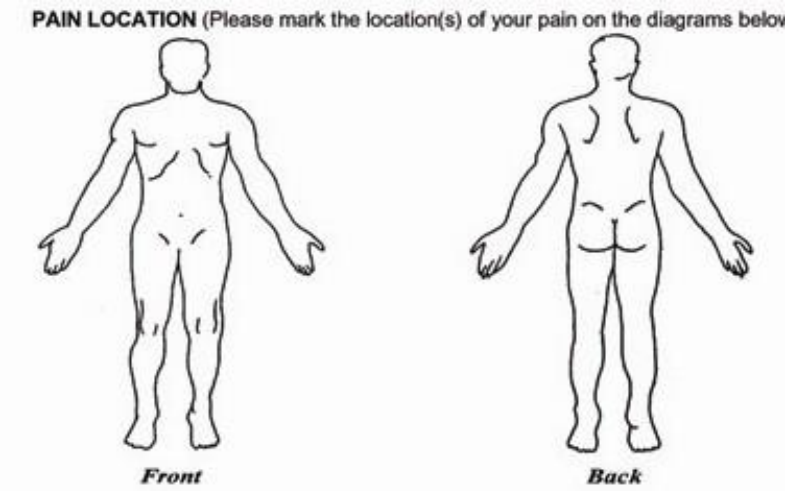
MIDLANDS orthopaedics & NEUROSURGERY

Patient Name: _____
Date of Birth:_____**Appt Date** _____
Chart Number: _____

PAIN LOCATION (Please mark the location(s) of your pain on the diagrams below



Circle your average level of pain in your back and/or neck:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Circle your average level of pain in your leg and/or arm:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How did your pain start? Check all that apply to you.
__ Suddenly Lifting_____Bending_____Fall_____Gradually_____Twisting_____Pulling_____Accident_____No apparent

Please indicate which activities below increase, decrease or cause no change in the level of your pain.

	Lying	Standing	Bending Forward	Bending Backward	Twisting	Sitting	Walking	Coughing Sneezing	Exercise (during)	Exercise (after)
Increases Pain										
Reduces pain										
No change										

Please check the approximate amount of time you can perform the following activities.

	unable	15 minutes	30 minutes	45 minutes	1 hour	indefinitely
Sit						
Stand						
Walk						

What treatments have you tried for this current pain?

___Physical Therapy ___Chiropractic _Acupuncture ___Home Exercises ___Surgery ___None

If surgery becomes a treatment option, would you consider it?_____yes ___no ___maybe

REVIEW OF SYMPTOMS - Please check ALL items that apply to you.

- ☐ Weight Loss/Gain
- ☐ Fever
- ☐ Arm Numbness
- ☐ Stiffness
- ☐ Severe Nighttime Pain
- ☐ Difficulty Buttoning Buttons
- ☐ Change in Handwriting Ability
- ☐ Night Sweats
- ☐ Recent Infections
- ☐ Leg Numbness
- ☐ Swelling
- ☐ Difficulty Walking
- ☐ Rashes
- ☐ Changes in Appetite
- ☐ Poor Sleep
- ☐ Fatigue
- ☐ Muscle Weakness
- ☐ Joint Pain
- ☐ Genital Numbness
- ☐ Bowel Accidents/Incontinence
- ☐ Mood Changes Agitation/Anxiety
- ☐ Bladder Accidents/Incontinence
- ☐ Bleeding/Bruising Problems
- ☐ Blurred Vision
- ☐ Dizziness
- ☐ Recent Chest Pain
- ☐ Shortness of Breath
- ☐ Other (describe): _____

MIDLANDS orthopaedics & NEUROSURGERY

Patient Name: _____
Date of Birth: _____ Appt Date _____
Chart Number: _____

Please read: This questionnaire has been designed to give the doctor information on how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one answer that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes your problem.

Section 1 - Pain Intensity

- ☐ I can tolerate the pain I have without having to use painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I don not use them.

Section 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself but I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need some help everyday in most aspects of selfcare.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor. But I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a stick/cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit still in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than an hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more then 30 minutes.
- ☐ Pain prevents me from standing more then 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ Pain does not prevent me from sleeping at all.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than 6 hours sleep.
- ☐ Even when I take tablets, I have less than 4 hours sleep.
- ☐ Even when I take tablets, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex Life

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social Life

- ☐ My social life is normal and gives no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 - Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I can manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short, necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

This spine follow-up form was reviewed by _____ **MD/NP Date:** _____