

# Donald S. Corenman, MD

## New Patient Cervical Spine History

Date:

/  /

*Please PRINT and fill out completely.*

Shade circles like this: ●

Med record #

Name \_\_\_\_\_ Age \_\_\_\_\_ yrs. D.O.B. \_\_\_\_\_

Height  ft  in Weight  lbs Sex  Male  Female Are you or could you be pregnant?  Yes  No

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to this office?  Dr. \_\_\_\_\_  PA/NP \_\_\_\_\_  
 If more than one, please note.  Friend/Word of Mouth \_\_\_\_\_  Physical Therapist \_\_\_\_\_  
 Family Member \_\_\_\_\_  Other \_\_\_\_\_

### HISTORY OF CARE

Who is your primary care physician? \_\_\_\_\_ Location: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name	City	Date of First Visit	Currently Continuing?

### HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe all details of any accident, incident or the way these problems began:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### CURRENT SYMPTOMS

What time of day is your pain at its worst?  Morning  Afternoon  Evening  Night  Not Applicable

Does the pain wake you up at night?  Yes  No

In the past six months have you experienced:  Fever  Weight Loss \_\_\_\_\_ lbs  
 Chills  Night Sweats

How would you describe your pain?  Constant  Constant, but worse with activity  
 Intermittent (comes and goes)  Intermittent, but worse with activity

Do you have full control of your bladder?  Yes  No

Do you have full control of your bowels?  Yes  No

# PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, include all affected areas.

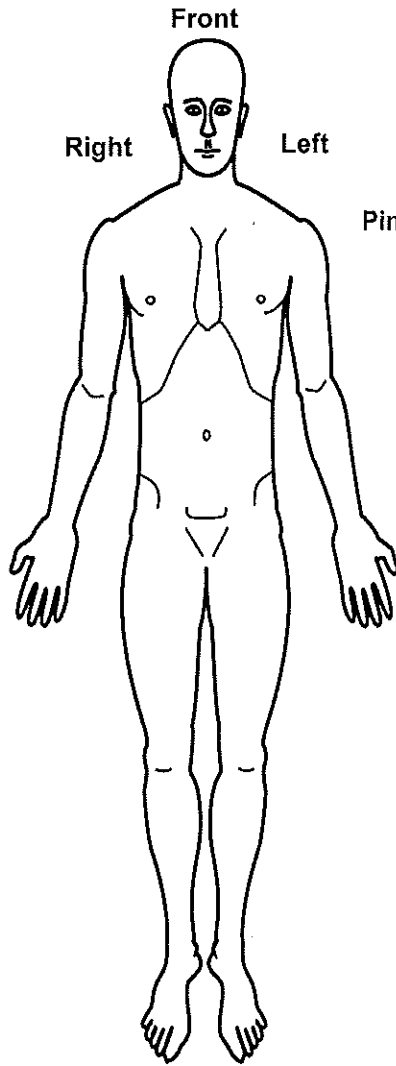


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**For Doctor Use Only**

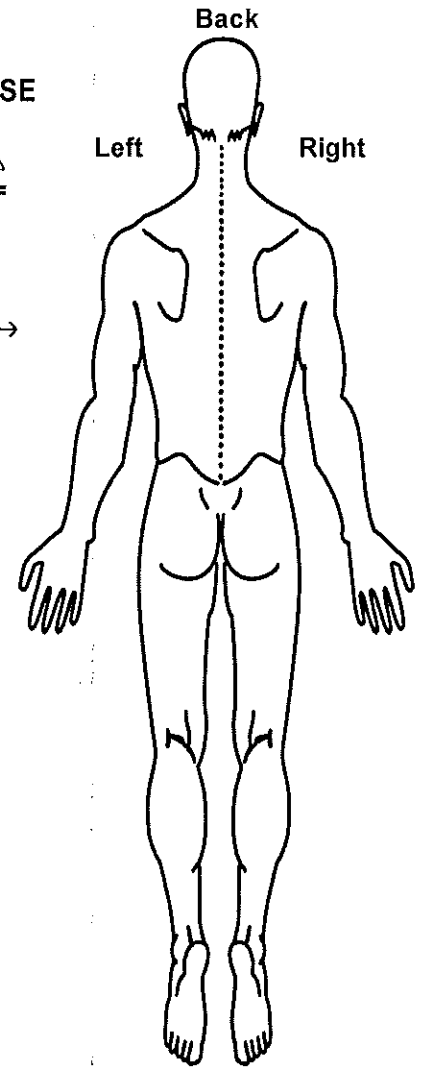
	R	L	Both/axial
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scp/ Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LB/SI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bt/Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M Bk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complex  Positional



## SYMBOLS TO USE

- Aching:  $\triangle\triangle\triangle$
- Numbness: =====
- Pins & Needles: OOO
- Burning: XXX
- Stabbing: ///
- Radiates:  $\rightarrow\rightarrow\rightarrow$



**For Dr. Use Only**

For each area of your body, please mark where your symptoms (pain, numbness, weakness, etc.) exist on "average" (most of the time) and at their "worst."

Neck <input type="checkbox"/> Positional	Current neck pain	<u>None</u>																<u>Unbearable</u>
	Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sh <input type="checkbox"/> Positional	Current shoulder pain																	
	Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm <input type="checkbox"/> Positional	Current arm pain																	
	Average	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PAST MEDICAL HISTORY

Check if you currently are being treated for or have been diagnosed with:

	<i>When?</i>		<i>When?</i>
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Kidney Disease/Problem	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Heart Disease or Attack	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> High Lipids (cholesterol, etc.)	_____	<input type="checkbox"/> Psoriasis	_____
<input type="checkbox"/> Ulcer Disease	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Gastritis	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Reflux Disease (GERD)	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Herpes Simplex	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> <b>Other</b>	_____
<input type="checkbox"/> Bipolar Disease	_____		
<input type="checkbox"/> Other Psychiatric	_____		

Have you ever had a history of blood clots or pulmonary embolus?     Yes     No

## SURGERIES

Please list all **spine** surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **other** surgeries you have had in the past:

<i>Type of Surgery</i>	<i>Date</i>	<i>Surgeon</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

## MEDICATIONS

Please list ALL medications you are **currently** taking, including prescription and over the counter:

<i>Medication</i>	<i>Dosage</i>	<i>Frequency (how many pills in a 24 hours)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## ALLERGIES

Please list any **allergies or adverse reactions** you have to medications:

<i>Medication</i>	<i>What Happened?</i>
_____	_____
_____	_____
_____	_____

## FAMILY HISTORY

Is your father alive?  Yes  No IF YES, age and any major medical problems? \_\_\_\_\_  
IF NO, age at time of death? \_\_\_\_\_ What major medical problems did he have? \_\_\_\_\_  
Is your mother alive?  Yes  No IF YES, age and any major medical problems? \_\_\_\_\_  
IF NO, age at time of death? \_\_\_\_\_ What major medical problems did she have? \_\_\_\_\_  
Any siblings?  Yes  No How many? \_\_\_\_\_

## SOCIAL HISTORY

Marital Status:  Married  Single  Divorced  Widowed  Living with other  
Education level achieved:  Grade School  Jr. High  High School  College  Post. Graduate  
DO you currently smoke cigarettes?  Yes  No Number of Years Smoked:   For Dr. Use Only p yrs    
Packs per Day: (Please choose the closest)  < 1/2  1/2  1  2  > 2  
DID you smoke cigarettes in the past?  Yes  No Number of Years Smoked:   Quit Date:  /  /   
Packs per Day: (Please choose the closest)  < 1/2  1/2  1  2  > 2  
Do you use any other tobacco products?  Yes  No What kind? \_\_\_\_\_ Quantity: \_\_\_\_\_  
Do you use any recreational drugs?  Yes  No What kind? \_\_\_\_\_  
Do you drink alcohol?  Yes  No Drinks per Day:   Drinks per Week:   Years: \_\_\_\_\_  
DO YOU HAVE OR HAVE YOU HAD an unhealthy relationship with alcohol?  Yes  No  
Type of alcohol consumption:  Beer  Wine  Mixed Drinks

## WORK HISTORY

Are you currently:  employed  unemployed  retired  on sick leave  on disability  a stay at home parent  
Has your job changed since your symptoms started?  Yes  No  Not Working  
If you are at a different job or not working, did your symptoms play a role  Yes  No  
in your job change or decision not to work?  
If you are working, are you on:  Normal duties  Light duties  
If you are on light duty, did your current symptoms play a role?  Yes  No  
Are you applying for disability?  Yes  No  
Please describe your job \_\_\_\_\_

## WORKMAN'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE?  Yes  No  
Have you had any PRIOR workers compensation injuries?  Yes  No If yes, how many?    
Please list any prior workers compensation cases/injuries:  

Date	Area Injured	Time off Work	Who Treated You?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were you at work when your symptoms began?  Yes  No  
Did you have a specific accident or injury while at work to cause your symptoms?  Yes  No  
What is the company name? \_\_\_\_\_  
Prior to your WC injury, how long had you been employed by that company?   months OR   years  
Do you currently have an attorney for this episode?  Yes  No

# CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT?  Yes  No

Have you had any PRIOR car accidents?  Yes  No If yes, how many?

Please list:	Date	Area Injured	Time off Work	Who Treated You?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you currently have an attorney for this episode?  Yes  No

## REVIEW OF SYSTEMS

Check No or Yes in the following areas. If "Yes," please describe:

### 1. CONSTITUTIONAL

- A. Recent weight change?  Yes  No \_\_\_\_\_
- B. Change or loss of appetite?  Yes  No \_\_\_\_\_
- C. Fevers?  Yes  No \_\_\_\_\_
- D. Chills?  Yes  No \_\_\_\_\_
- E. Night sweats?  Yes  No \_\_\_\_\_
- F. Weakness fatigue  Yes  No \_\_\_\_\_

### 2. EYES

- A. Vision change?  Yes  No \_\_\_\_\_
- B. Glasses/contacts?  Yes  No \_\_\_\_\_
- C. Glaucoma?  Yes  No \_\_\_\_\_
- D. Eye infections (iritis)?  Yes  No \_\_\_\_\_
- E. Loss of vision?  Yes  No \_\_\_\_\_

### 3. EARS, NOSE, AND THROAT

- A. Decrease or loss of hearing?  Yes  No \_\_\_\_\_
- B. Ear ache or infection?  Yes  No \_\_\_\_\_
- C. Tinnitus (ringing in ear)?  Yes  No \_\_\_\_\_
- D. Nasal stuffiness/discharge?  Yes  No \_\_\_\_\_
- E. Nosebleeds?  Yes  No \_\_\_\_\_
- F. Sore throat?  Yes  No \_\_\_\_\_
- G. Hoarseness?  Yes  No \_\_\_\_\_
- H. Dental problems?  Yes  No \_\_\_\_\_
- I. Dentures?  Yes  No \_\_\_\_\_
- J. Difficult swallowing?  Yes  No \_\_\_\_\_

### 4. CARDIOVASCULAR

- A. Chest pain?  Yes  No \_\_\_\_\_
- B. Shortness of breath?  Yes  No \_\_\_\_\_
- C. Palpitations?  Yes  No \_\_\_\_\_
- D. Swelling in the legs?  Yes  No \_\_\_\_\_

E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER

### 5. RESPIRATORY

- A. Cough?  Yes  No \_\_\_\_\_
- B. Wheezing/asthma?  Yes  No \_\_\_\_\_
- C. Pneumonia or bronchitis?  Yes  No \_\_\_\_\_
- D. Shortness of breath?  Yes  No \_\_\_\_\_

**6. GASTROINTESTINAL**

- A. Abdominal pain?  Yes  No \_\_\_\_\_
- B. Nausea or vomiting?  Yes  No \_\_\_\_\_
- C. Constipation?  Yes  No \_\_\_\_\_
- D. Diarrhea?  Yes  No \_\_\_\_\_
- E. Heartburn/acid reflux?  Yes  No \_\_\_\_\_
- F. Rectal bleeding or black, tarry stools?  Yes  No \_\_\_\_\_

**7. GENITOURINARY**

- A. Increase frequency of urination?  Yes  No \_\_\_\_\_
- B. Pain/burning when you urinate?  Yes  No \_\_\_\_\_
- C. Frequent infection of urine?  Yes  No \_\_\_\_\_
- D. Incontinence (loss of control)?  Yes  No \_\_\_\_\_
- E. Reduced force of urination?  Yes  No \_\_\_\_\_

**8. MUSCULOSKELETAL**

- A. Muscle aches?  Yes  No \_\_\_\_\_
- B. Joint pains/stiffness (arthritis)?  Yes  No \_\_\_\_\_
- C. Swelling of joints?  Yes  No \_\_\_\_\_

**9. SKIN**

- A. Rash?  Yes  No \_\_\_\_\_
- B. Lumps or sores?  Yes  No \_\_\_\_\_
- C. Changes in hair or nails?  Yes  No \_\_\_\_\_
- D. Dryness?  Yes  No \_\_\_\_\_
- E. Ulcers?  Yes  No \_\_\_\_\_
- F. Abnormal scars?  Yes  No \_\_\_\_\_

**10. NEUROLOGICAL**

- A. Headaches?  Yes  No \_\_\_\_\_
- B. Fainting/blackouts?  Yes  No \_\_\_\_\_
- C. Tremors/involuntary movements?  Yes  No \_\_\_\_\_
- D. Numbness, tingling?  Yes  No \_\_\_\_\_
- E. Dizziness?  Yes  No \_\_\_\_\_
- F. Muscle weakness?  Yes  No \_\_\_\_\_

**11. PSYCHIATRIC**

- A. Depression?  Yes  No \_\_\_\_\_
- B. Mood swings?  Yes  No \_\_\_\_\_
- C. Anger?  Yes  No \_\_\_\_\_
- D. Nervousness/anxiety?  Yes  No \_\_\_\_\_

**12. ENDOCRINE**

- A. Excessive thirst or hunger?  Yes  No \_\_\_\_\_
- B. Hot/cold intolerance?  Yes  No \_\_\_\_\_
- C. Hot flashes?  Yes  No \_\_\_\_\_

**13. HEMATOLOGICAL**

- A. Easy bruising or bleeding?  Yes  No \_\_\_\_\_
- B. Past blood transfusions?  Yes  No \_\_\_\_\_





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## WORK/ACTIVITIES OF DAILY LIVING (ADL) SCALE

Please fill out the following scale regarding **ACTIVITIES** that you currently perform **AT WORK AND/OR AT HOME**. Pick the category/level that best fits your activity level. Thank you!

- 0 **Not Working and No Activities at Home** On sick leave or just not working and on bed rest (do not perform any activities of daily living such as cooking, cleaning the house, laundry, etc)
- 1 **Minimal Sedentary Work/ADL** Activities involve mostly sitting or lying down with frequent position change if necessary, working on a few tasks (at work or at home) per day but resting most of the time, occasionally lifting 5 pounds or less, rarely walking
- 2 **Sedentary Work/ADL** Activities involve mostly sitting (or standing if pain prevents sitting) with frequent position change if necessary, occasionally lifting or carrying 10 pounds or less, walking less than 1 hour per day, no bending, squatting, reaching, and/or twisting
- 3 **Mostly Sedentary Work/ADL** Activities involve mostly sitting or standing with frequent position change if necessary, more frequent lifting or carrying of 10 pounds or less, can include walking 1 hour per day and/or minimal bending, squatting, reaching, and/or twisting
- 4 **Very Light Work/ADL** More frequent lifting or carrying of 10 pounds, occasionally lifting up to 15 pounds, can include walking around 2 hours per day and/or bending, stooping, squatting, reaching, and/or twisting up to 10 times per hour
- 5 **Light Work/ADL** More frequent lifting or carrying an average of 10-15 pounds, occasionally lifting up to 20 pounds, can include walking around 3 hours per day and/or bending, stooping, squatting, reaching, and/or twisting up to 15 times per hour
- 6 **Light-Medium Work/ADL** More frequent lifting or carrying of 20 pounds, occasionally lifting up to 35 pounds, can include walking around 3-4 hours per day and/or bending, stooping, squatting, reaching, and/or twisting up to 20 times per hour
- 7 **Medium Work/ADL** Frequent lifting of 20 pounds, occasionally lifting up to 50 pounds -can include walking around 4 hours per day -and/or bending, stooping, squatting, reaching, and/or twisting up to 30 times per hour and/or climbing ladders
- 8 **Medium-Heavy Work/ADL** Frequent lifting of 35 pounds, occasionally lifting 50 pounds, can include walking around 4-5 hours per day, and/or bending, squatting, reaching, and/or twisting up to 40 times per hour and/or climbing ladders
- 9 **Heavy Work** Frequent lifting of up to 50 pounds, occasionally lifting up to 100 pounds, can include walking 5 hours per day and/or bending, squatting, reaching, and/or twisting up to 50 times per hour, and/or climbing scaffolding and occasionally climbing poles
- 10 **Very Heavy Work/ADL** Very frequent lifting of more than 50 pounds, occasionally lifting over 100 pounds, constantly lifting at least 20 pounds, can include walking 7 hours per day or more and/or bending, squatting, reaching, and/or twisting 60 or more times per hour and/or climbing scaffolding, poles, or ropes

## EXPECTATIONS

What are your expectations from your treatment? (Mark one response on each line.)

	Not at all likely	Slightly likely	Somewhat likely	Very likely	Extremely likely	Not Applicable
1. Relief from symptoms (pain, stiffness, swelling, numbness, weakness, instability)	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA
2. To do more everyday household or yard activities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA
3. To sleep more	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA
4. To go back to my usual job	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA
5. To exercise and do recreational activities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA
6. To prevent future disability	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> NA

# AGGRAVATING ACTIVITIES

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Please scale to what extent the following activities aggravate (make worse) or relieve your symptoms.

	<u>Neck</u>				<u>Shoulder/Arm/Hand</u>			
	<u>No Symptoms</u>	<u>Slight</u>	<u>Moderate</u>	<u>Severe</u>	<u>No Symptoms</u>	<u>Slight</u>	<u>Moderate</u>	<u>Severe</u>
Biking on flat terrain/riding an upright stationary bike	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Overhead work or shooting a basketball or catching a pop-fly or any other motion where you must look up or bend backwards.	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Working on a computer for 5 minutes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Working on a computer for 30 minutes or greater	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Turning to look to the side (as if changing lanes when driving)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Riding in a car on a bumpy road	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Biking on a bumpy road or trail	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Driving or riding in a car for approximately 5 minutes	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Driving or riding in a car for 30 minutes or greater	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Staying in one position for a long period of time/ prolonged nonmovement	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Reading for approximately 5 minutes (with the reading material held in your lap/looking down)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Reading for 30 minutes or greater	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Lifting less than 20 lbs	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Lifting more than 20 lbs	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Jumping up and down	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Coughing or sneezing	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Unexpected sudden movements	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Sleeping through the night	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

**HOW MUCH DIFFICULTY do you have with the following activities? (How hard is it to do these actions?)**

	<u>None</u>	<u>Slight</u>	<u>Moderate</u>	<u>Severe</u>
Balancing when walking?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Walking in the pitch dark?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Handwriting?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Any weakness in both hands?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Picking up a coin	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Holding objects without dropping them	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Buttoning buttons	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3





# SF-12 HEALTH SURVEY™

**INSTRUCTIONS:** This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

Shade circles like this: ●  
Not like this: ⊗ ✓

1) In general, would you say your health is:     Excellent     Very Good     Good     Fair     Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

	Yes, limited	Yes, limited a little	No, not limited at all
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3) Climbing several flights of stairs

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4) Accomplished less than you would like

	Yes	No
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5) Were limited in the kind of work or other activities

<input type="radio"/>	<input type="radio"/>
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During the past week, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6) Accomplished less than you would like

	Yes	No
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7) Didn't do work or other activities as carefully as usual

<input type="radio"/>	<input type="radio"/>
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8) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

<input type="radio"/> Not at all	<input type="radio"/> Quite a bit
<input type="radio"/> A little bit	<input type="radio"/> Extremely
<input type="radio"/> Moderately	

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past Weeks:

	All of the Time	Most of the Time	A good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9) Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10) Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11) Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12) During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

<input type="radio"/> All of the time	<input type="radio"/> Some of the time	<input type="radio"/> None of the time
<input type="radio"/> Most of the time	<input type="radio"/> A little of the time	

If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

1. Very dissatisfied     2. Somewhat dissatisfied     3. Neutral     4. Somewhat satisfied     5. Very satisfied