

Donald S. Corenman, MD

New Patient Lumbar 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 Intermittent, but worse with activity
 (comes and goes)
 Do you have full control of your bladder? Yes No
 Do you have full control of your bowels? Yes No

PATIENT PAIN DRAWING



17777

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.

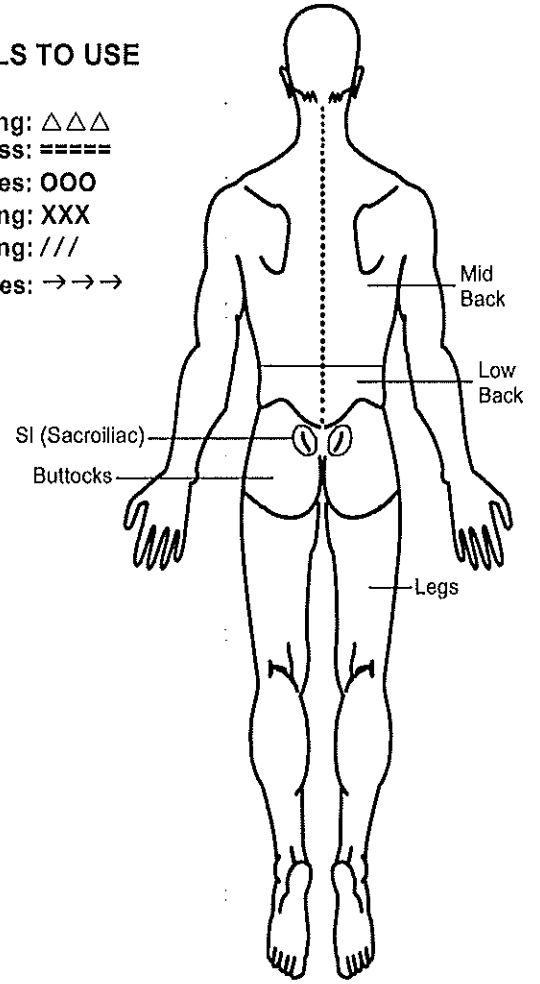
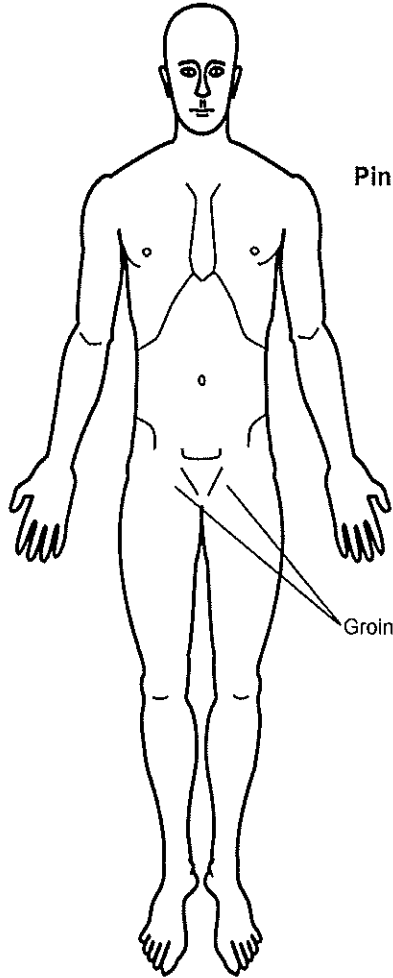
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	R	L	Both/axial
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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/Sl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bl/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: $\rightarrow\rightarrow\rightarrow$



Mark where any symptoms (pain, numbness, weakness, etc.) exist on average (most of the time) and at their worst.

		None									Unbearable	
Current mid back pain	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
Current low back pain	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
Current SI pain	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
Current buttock	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
Current groin pain	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
Current leg pain	Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
	Worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10

For Dr. Use Only

MB Positional

LB Positional

SI Positional

Buttock Positional

Gr Positional

Lg Positional

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"/> Other	_____
<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 in your job change or decision not to work? Yes No
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 _____



Steadman Philippon Research Institute

New Patient or New Injury - LUMBAR

Med record #

Name

Today's Date: / /

Height ft in Weight lbs

Do you currently smoke cigarettes? Yes No

What date did your current spinal problems begin? / /

Was it an immediate or gradual onset? immediate gradual

TREATMENTS AND PAIN MEDICATIONS

Check any of the following treatments you have had FOR THE PART OF YOUR SPINE BEING EVALUATED TODAY. If you have a chronic/long term spinal problem, please just check the treatments you have received in the PAST 3 YEARS: Physical Therapy Yoga Pilates Chiropractic Massage Acupuncture Spine Injection

None Other

What medications do you currently take for pain? NSAIDS and Tylenol Narcotics No Medications/Drugs for Pain OTHER

If you are taking Narcotics, which of the following medications do you take? If daily, please indicate the total milligrams per day. If you take any of the following only occasionally, please check intermittent.

- Percocet mg per day intermittent Oxycontin/MSContin/MSIR/Morphine mg per day intermittent
- Vicodin mg per day intermittent Other
- Dilaudid mg per day intermittent Other

SPORTS/ACTIVITIES/WORK

Do you participate in sports? Yes No

Do you consider the onset of your symptoms to be due to a sport or a sports injury? Yes No

On average, how many hours per week do you *currently* spend participating in sports? hours per week

In which 3 primary sports/activities do you spend the most time?

- | | | | | | |
|---|--|--|--------------------|--|--------------------|
| | sedentary | | recreational | | elite/pro |
| Your activity level in sports TODAY is: | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | | | | |
| To what level of sports would you like to return? | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | | | | |
| | not limited | | moderately limited | | completely limited |
| How limited are you right now in your sports? | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | | | | |
| How limited are you right now in your ability to WORK at your job and/or at home? | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 | | | | |

For Dr. Use Only	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9
	1 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	2 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	3 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
	1	2	3



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AGGRAVATING ACTIVITIES

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

	<u>Back</u>				<u>SI (Sacroiliac)/Buttock/Groin/Leg</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>
Standing 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
Standing 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
Walking 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
Walking 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
Overhead work or shooting a basketball or catching a pop-fly or any other motion where you must bend	<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
Squatting	<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
Lying on your stomach	<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
Leaning over a shopping cart	<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 in a fetal position	<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
Standing up straight after getting out of bed	<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 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 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
Sitting 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
Sitting for 30 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
Sitting through a movie	<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
Biking on flat terrain/riding a 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
Bending and lifting something heavy	<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
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
Any painful clicks or pops with motion?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3				
Getting into or out of a car	<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
Putting on socks and shoes	<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
Going up one flight of stairs	<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
Going down one flight of stairs	<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



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OSWESTRY LOW BACK PAIN DISABILITY INDEX

Please read instructions:

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 and mark in each section only the ONE box that applies to you. We realize 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.

Shade circles like this: ●

Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Personal Care (Washing, Dressing, etc)

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

Lifting

- I can lift heavy weights without 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

Walking

- Pain does not prevent me walking any distance
- Pain prevents me walking more than 1 mile
- Pain prevents me walking more than 1/4 of a mile
- Pain prevents me walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Sitting

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

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 for more than 1 hour
- Pain prevents me from standing for more than 1/2 hour
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours of sleep
- Because of pain I have less than 4 hours of sleep
- Because of pain I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

Sex Life (if applicable)

- 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

Social Life

- My social life is normal and causes me no extra pain
- My social life is normal, but increases the degree of pain
- Pain has no significant effect of my social life apart from limiting my more energetic interests, e.g., sports, 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

Traveling

- I can travel anywhere without pain
- I can travel anywhere but it gives extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment



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?	Yes, limited	Yes, limited a little	No, not limited at all
2) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Climbing several flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?	Yes	No
4) Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>
5) Were limited in the kind of work or other activities	<input type="radio"/>	<input type="radio"/>

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)?	Yes	No
6) Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>
7) Didn't do work or other activities as carefully as usual	<input type="radio"/>	<input type="radio"/>

8) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all Quite a bit
 A little bit Extremely
 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.)?

All of the time Some of the time None of the time
 Most of the time 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