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? If more than one, please note.
○ Dr. ______________ ○ PA/NP ______________
○ 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

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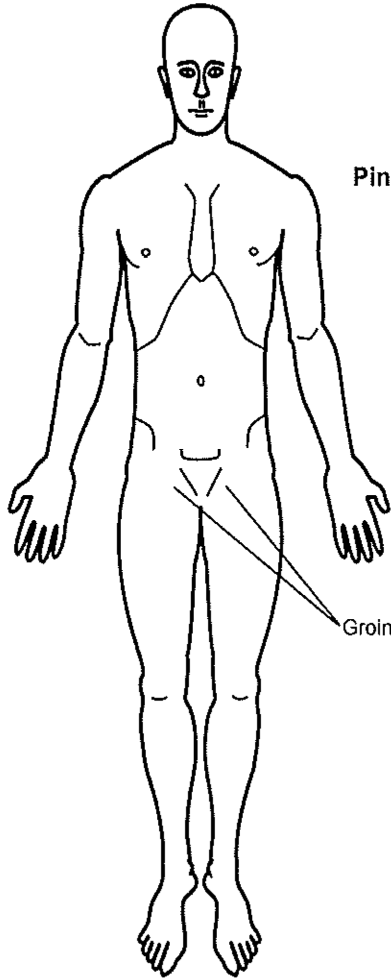
PATIENT PAIN DRAWING

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.

For Doctor Use Only

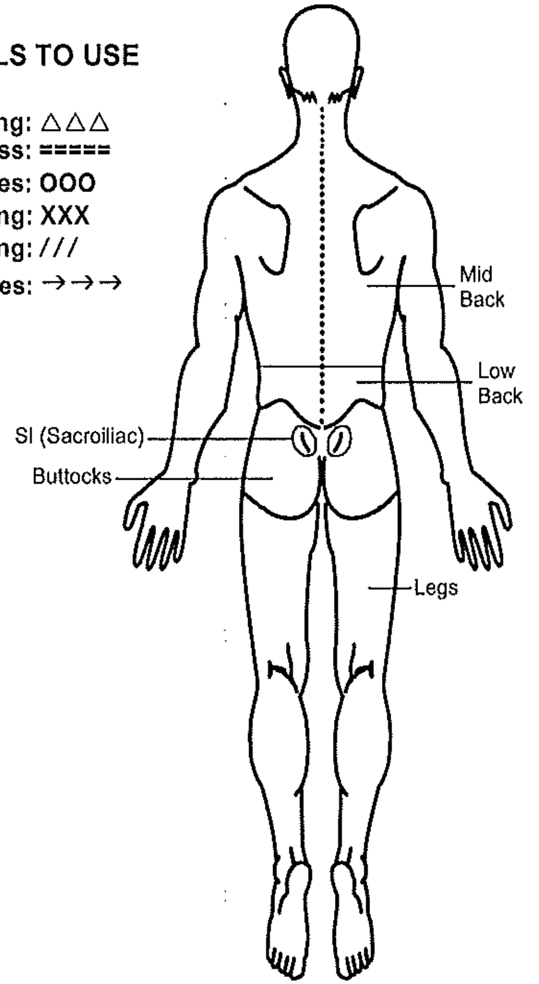
	R			L			Both/axial		
Head									
Neck									
Trap									
Scap									
Scp/ Arm									
Arm									
LB									
LB/SI									
SI									
Bt/Leg									
M Bk									
Groin									

Complex O Positional O



SYMBOLS TO USE

Aching: △△△
Numbness: =====
Pins & Needles: OOO
Burning: XXX
Stabbing: ///
Radiates: →→→



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**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Current **low back** pain	**Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Current **SI** pain	**Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Current **buttock**	**Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Current **groin** pain	**Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
Current **leg** pain	**Average**	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
	Worst	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

For Dr. Use Only
MB O Positional
LB O Positional
SI O Positional
Buttock O Positional
Gr O Positional
Lg O Positional

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PAST MEDICAL HISTORY

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

	When?		*When?*
○ High Blood Pressure		○ Osteoporosis	
○ Diabetes		○ Kidney Disease/Problem	
○ Liver Disease		○ Seizures	
○ Heart Disease or Attack		○ Arthritis	
○ Stroke		○ Thyroid	
○ Cancer		○ Tuberculosis	
○ High Lipids (cholesterol, etc.)		○ Psoriasis	
○ Ulcer Disease		○ Polio	
○ Gastritis		○ Rheumatic Fever	
○ Reflux Disease (GERD)		○ Gout	
○ Asthma		○ Herpes Simplex	
○ Depression		○ **Other**	
○ Bipolar Disease			
○ 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:

Type of Surgery	*Date*	*Surgeon*

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

Type of Surgery	*Date*	*Surgeon*

MEDICATIONS

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

Medication	*Dosage*	*Frequency (how many pills in a 24 hours)*

ALLERGIES

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

Medication	*What Happened?*

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 ______

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Steadman Philippon Research Institute
New Patient or New Injury - LUMBAR

Med record # ☐☐☐☐☐☐

Today's Date: ☐☐/☐☐/☐☐☐☐

Name ____________________

Height ☐ ft ☐☐ in Weight ☐☐☐ lbs

Do you currently smoke cigarettes? O Yes O No

What date did your current spinal problems begin? ☐☐/☐☐/☐☐☐☐

Was it an immediate or gradual onset? O immediate O 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: O Physical Therapy O Yoga O Pilates O Chiropractic O Massage O Acupuncture O Spine Injection

O None O Other ____________________

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

O Percocet ☐☐☐ mg per day O intermittent

O Vicodin ☐☐☐ mg per day O intermittent

O Dilaudid ☐☐☐ mg per day O intermittent

O Oxycontin/MSContin/MSIR/Morphine ☐☐☐ mg per day O intermittent

O Other ____________________ ☐☐☐ mg per day O intermittent

SPORTS/ACTIVITIES/WORK

Do you participate in sports? O Yes O No

Do you consider the onset of your symptoms to be due to a sport or a sports injury? O Yes O 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:	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
To what level of sports would you like to return?	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

	not limited					moderately limited					completely limited
How limited are you right now in your sports?	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10
How limited are you right now in your ability to WORK at your job and/or at home?	O 0	O 1	O 2	O 3	O 4	O 5	O 6	O 7	O 8	O 9	O 10

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sport 1: 0 1 2 3 4 5 6 7 8 9 — OOOOOOOOOO / OOOOOOOOOO
2: 0 1 2 3 4 5 6 7 8 9 — OOOOOOOOOO / OOOOOOOOOO
3: 0 1 2 3 4 5 6 7 8 9 — OOOOOOOOOO / OOOOOOOOOO

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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!

O 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)

O 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

O 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

O 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

O 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

O 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

O 6 **Light-Medium Work/ADL**More frequent lifting or carrying of 20 pounds, occassionally 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

O 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

O 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, squating, reaching, and/or twisting up to 40 times per hour and/or climbing ladders

O 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

O 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)	O 1	O 2	O 3	O 4	O 5	O NA
2. To do more everyday household or yard activities	O 1	O 2	O 3	O 4	O 5	O NA
3. To sleep more	O 1	O 2	O 3	O 4	O 5	O NA
4. To go back to my usual job	O 1	O 2	O 3	O 4	O 5	O NA
5. To exercise and do recreational activities	O 1	O 2	O 3	O 4	O 5	O NA
6. To prevent future disability	O 1	O 2	O 3	O 4	O 5	O NA

Thank you for filling out this questionnaire. Even if you feel great, we would like you to complete the form.
If you would like to receive your questionnaires via e-mail please enter your e-mail address here:

By completing this form, you agree to allow the Steadman Philippon Research Institute to use this data and future questionnaire data for research purposes only. All data is kept anonymous. It is our goal to monitor patient outcomes in an effort to improve quality of care. Your input is crucial to our mission. If you have any questions or would like more information about the foundation, please contact us via e-mail at clinicalresearch@sprivail.org or visit our website at www.sprivail.org.
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AGGRAVATING ACTIVITIES

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

	Back				SI (Sacroiliac)/Buttock/Groin/Leg			
	No Symptoms	Slight	Moderate	Severe	No Symptoms	Slight	Moderate	Severe
Standing for 5 minutes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Standing for 30 minutes or greater	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Walking for 5 minutes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Walking for 30 minutes or greater	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Overhead work or shooting a basketball or catching a pop-fly or any other motion where you must bend	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Squatting	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Lying on your stomach	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Leaning over a shopping cart	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Sleeping in a fetal position	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Standing up straight after getting out of bed	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Driving for approximately 5 minutes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Driving for 30 minutes or greater	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Sitting for 5 minutes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Sitting for 30 minutes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Sitting through a movie	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Staying in one position for a long period of time/ prolonged nonmovement	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Biking on flat terrain/riding a stationary bike	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Bending and lifting something heavy	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Riding in a car on a bumpy road	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Jumping up and down	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Coughing or sneezing	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Unexpected sudden movements	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Any painful clicks or pops with motion?	O 0	O 1	O 2	O 3				
Getting into or out of a car	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Putting on socks and shoes	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Going up one flight of stairs	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Going down one flight of stairs	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 3
Sleeping through the night	O 0	O 1	O 2	O 3	O 0	O 1	O 2	O 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
- O I have no pain at the moment
- O The pain is very mild at the moment
- O The pain is moderate at the moment
- O The pain is fairly severe at the moment
- O The pain is very severe at the moment
- O The pain is the worst imaginable at the moment

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

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

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

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

Standing
- O I can stand as long as I want without extra pain
- O I can stand as long as I want but it gives me extra pain
- O Pain prevents me from standing for more than 1 hour
- O Pain prevents me from standing for more than 1/2 hour
- O Pain prevents me from standing for more than 10 minutes
- O Pain prevents me from standing at all

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

Sex Life (if applicable)
- O My sex life is normal and causes no extra pain
- O My sex life is normal but causes some extra pain
- O My sex life is nearly normal but is very painful
- O My sex life is severely restricted by pain
- O My sex life is nearly absent because of pain
- O Pain prevents any sex life at all

Social Life
- O My social life is normal and causes me no extra pain
- O My social life is normal, but increases the degree of pain
- O Pain has no significant effect of my social life apart from limiting my more energetic interests, e.g., sports, etc.
- O Pain has restricted my social life and I do not go out as often
- O Pain has restricted my social life to my home
- O I have no social life because of pain

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

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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: O Excellent O Very Good O Good O Fair O 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	O	O	O
3) Climbing several flights of stairs	O	O	O

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

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

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

O Not at all O Quite a bit
O A little bit O Extremely
O 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?	O	O	O	O	O	O
10) Did you have a lot of energy?	O	O	O	O	O	O
11) Have you felt downhearted and blue?	O	O	O	O	O	O

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.)?

O All of the time O Some of the time O None of the time
O Most of the time O 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?

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