

TAYLOR SPINE CLINIC

- Due to the complex nature of the spine there will be a delay in your appointment. Please expect to wait 1 to 2 hours before being seen. Please understand Dr Taylor will spend as much time with each patient as needed. If you are not able to wait please ask for the first appointment of the day to avoid a delay in your appointment or you may call prior to your scheduled visit to determine how long your wait will be prior to being seen on any given date.



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SPINE PATIENT QUESTIONNAIRE (Lumbar Attachment)

-  Please answer all questions completely
-  It is in your best interest and will assist your doctor with your care

NAME: _____ DATE: _____

BIRTHDATE: ____/____/____ HEIGHT: ____ FT. ____ IN. WEIGHT ____ LBS

A. 1. Referring doctor name and full address: _____

If not referred, how did you choose this office? _____

2. Internist or family doctor name and address: _____

3. Chief complaint Neck pain Arm: Pain Numbness Weakness
(check all that apply): Back pain Leg: Pain Numbness Weakness Other _____

4. Your age: _____ Years _____ Months

5. Your sex: Male Female

6. How long has the pain (or your problem) been present? _____

7. Has your problem worsened recently? No Yes – How recently? _____

8. What started the pain (or problem)? _____

B. For patients with NECK OR ARM pain, numbness or weakness:

(If you are seeing the doctor for back or leg pain, go to “C”)

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

- Neck 0%, Arm 100% Neck 10%, Arm 90% Neck 25%, Arm 75% Neck 40%, Arm 60%
 Neck 50%, Arm 50% Neck 60%, Arm 40% Neck 75%, Arm 25% Neck 90%, Arm 10%
 Neck 100%, Arm 0%

2. There is: No arm pain Arm pain is as follows (check the following):

- a. Right 0%, Left 100% Right 10%, Left 90% Right 25%, Left 75% Right 40%, Left 60%
 Right 50%, Left 50% Right 60%, Left 40% Right 75%, Left 25% Right 90%, Left 10%
 Right 100%, Left 0%

b. The arm pain is present in the (check the following):

- Right:** Upper back Shoulder Upper arm Forearm Hand/finger
Left: Upper back Shoulder Upper arm Forearm Hand/finger

3. Raising the arm: Improves the pain Worsens the pain Does not affect the pain

4. Moving the neck: Improves the pain Worsens the pain Does not affect the pain

5. There is: No weakness of the arms and hands Weakness of the (check the following):

- Right:** Shoulder Upper arm Forearm Hand/finger
Left: Shoulder Upper arm Forearm Hand/finger

6. There is: No numbness of the arms and hands Numbness of the (check the following):

- Right:** Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger
Left: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger

7. There (is is no) difficulty picking up small objects like coins or buttoning buttons.

8. There (is a is no) problem with balance or tripping frequently.

9. There are: (Frequent Occasional No) headaches in the back of the head.

END OF NECK QUESTIONS – PLEASE GO TO “D”

C. For patients with BACK OR LEG PAIN, numbness or weakness.

(If you are seeing the doctor for neck problems, please complete section "B")

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):

<input type="checkbox"/> Back 0%, Leg 100%	<input type="checkbox"/> Back 10%, Leg 90%	<input type="checkbox"/> Back 25%, Leg 75%	<input type="checkbox"/> Back 40%, Leg 60%
<input type="checkbox"/> Back 50%, Leg 50%	<input type="checkbox"/> Back 60%, Leg 40%	<input type="checkbox"/> Back 75%, Leg 25%	<input type="checkbox"/> Back 90%, Leg 10%
<input type="checkbox"/> Back 100%, Leg 0%			
2. There is: No leg pain Leg pain as follows (check the following):
 - a. Right 0%, Left 100% Right 10%, Left 90% Right 25%, Left 75% Right 40%, Left 60%
 - Right 50%, Left 50% Right 60%, Left 40% Right 75%, Left 25% Right 90%, Left 10%
 - Right 100%, Left 0%
 - b. The pain is present in the (check the following):

Right: <input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left: <input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
3. There is: No weakness of the legs Weakness of the (check the following):

Right: <input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
Left: <input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
4. There is: No numbness of the legs Numbness of the (check the following):

Right: <input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left: <input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
5. The worst position for the pain is: Sitting Standing Walking
6. How many minutes can you stand in one place without pain? 0-10 15-30 30-60 60+
7. How many minutes can you walk without pain? 0-10 15-30 30-60 60+
8. Lying down: Eases the pain Does not ease the pain Sometimes eases the pain
9. Bending forward: Increases the pain Decreases the pain Doesn't affect the pain

PLEASE GO TO "D"

D. ★★★ ALL PATIENTS SHOULD ANSWER THE FOLLOWING ★★★

1. Coughing or sneezing (Increases Sometimes increases Does not increase) the pain.
2. There is: No loss of bowel or bladder control Loss of bowel or bladder control since _____
3. I have: Not missed any work because of this problem Missed (how much?) _____ work
4. Treatments have included: No medicines, therapy, manipulations, injections, or braces

Neck Back

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy, exercise |
| <input type="checkbox"/> | <input type="checkbox"/> | Massage & ultrasound |
| <input type="checkbox"/> | <input type="checkbox"/> | Traction |
| <input type="checkbox"/> | <input type="checkbox"/> | Manipulation |
| <input type="checkbox"/> | <input type="checkbox"/> | Tens Unit |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injections |
| <input type="checkbox"/> | <input type="checkbox"/> | Braces |

Neck Back

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotic medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Epidural steroid injections _____ times which relieved the pain for (how long)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Trigger point injections _____ times which relieved the pain for (how long)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

5. List pain medications and dose taken for your spine problem: None

Medication	Dose

6. Previous doctors seen about this problem: None

Doctor	Specialty	City (If not St. Louis)	Treatments

7. Tests done to evaluate your problem, the dates and the location they were done: None

	Neck	Back	#1 DATE	WHERE	#2 DATE	WHERE	#3 DATE	WHERE
Plain x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
EMGs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____

E. REVIEW OF SYSTEMS: Check all that apply. None apply

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Reading glasses | <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Hot or cold spells |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Calf cramps w/ walking | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Burning on urination | Women only: |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Toothache | <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Gum trouble | <input type="checkbox"/> Get up more than once every night to urinate | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent spotting |
| <input type="checkbox"/> Morning cough | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Frequent rash | _____ |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Frequent belching | | _____ |
| <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Frequent diarrhea | | _____ |

F. MEDICAL HISTORY: Check all that apply. None apply

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> AIDS | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> Serious injuries (explain) |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood clot in lung | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Other: _____ |

G. SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. None

OPERATION	SURGEON	DATE

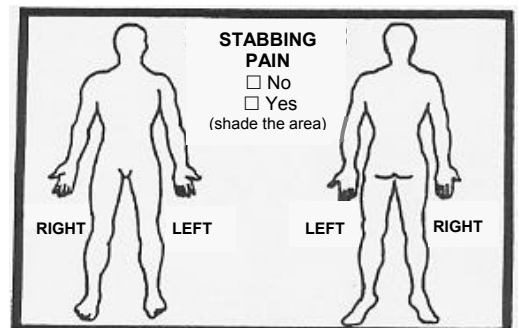
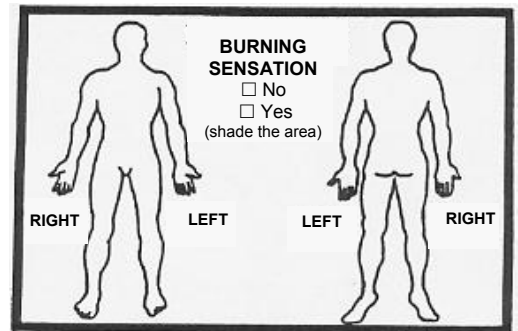
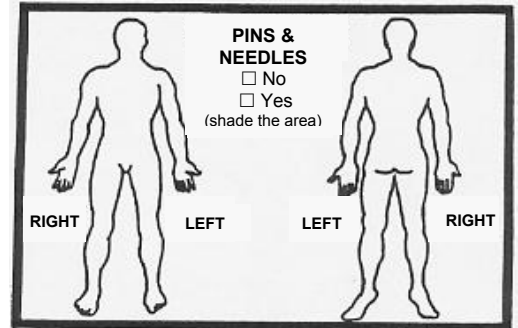
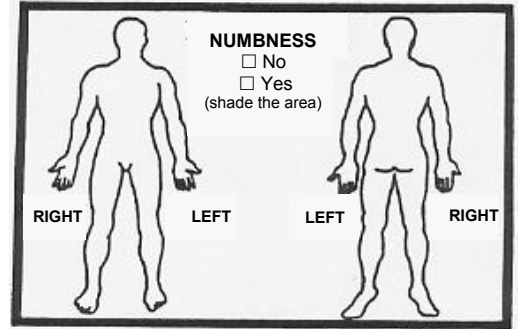
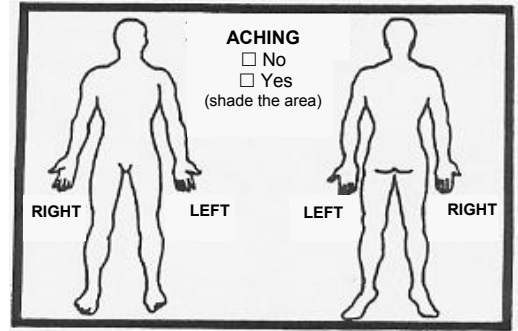
H. FAMILY HISTORY: Check all that apply. None apply

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney trouble or stones | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Bleeding disorders | _____ |

I. MEDICATIONS YOU TAKE: None

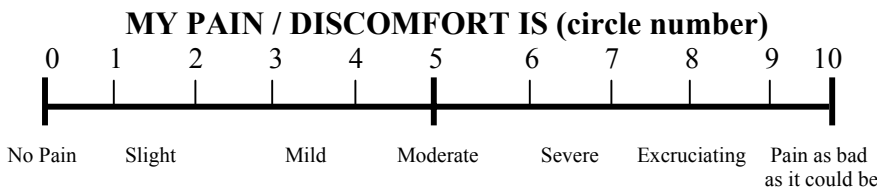
J. ALLERGIES TO MEDICATIONS: No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



K. SOCIAL HISTORY:

- Work status: Homemaker Retired Disabled On leave
 Unemployed Working: Full time Part time
 Occupation: _____
- Marital status: Married Single Co-habiting
 Widowed Divorced
- Number of living children: 1 2 3 4 5
 6 7 8 9 10
- I live: Alone With: _____
- Tobacco use: Never (skip to #6)
 Cigar Chew Pipe Cigarettes
 _____ packs per day for _____ years.
 Quit – When? _____ after smoking
 _____ packs per day for _____ years (total)
- Alcohol: Never or rare
 Social Frequently drunk (more than twice a week)
 Alcoholic Recovering alcoholic
- Drug overuse/abuse: Never Currently In the past
- Because of this spine problem, I have filed or plan to file:
 A lawsuit A Worker's Compensation claim
 Neither a lawsuit or Worker's Compensation claim



 Patient Signature

 Date

How often do you need to use the following assistive devices?

- One or two canes: Never Sometimes About half the time Often All of the time
 One or two crutches: Never Sometimes About half the time Often All of the time
 Walker: Never Sometimes About half the time Often All of the time
 Wheelchair: Never Sometimes About half the time Often All of the time

Which hurts more, your legs or back?

- Leg hurts much more Leg hurts somewhat more Hurt about the same
 Back hurts somewhat more Back hurts much more

In the past week, how often have you suffered: (Please circle the number that applies)

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Low back and/or buttock pain.....	1	2	3	4	5	6
2. Leg pain.....	1	2	3	4	5	6
3. Numbness or tingling in leg and/or foot.....	1	2	3	4	5	6
4. Weakness in leg and/or foot (such as difficulty lifting foot).....	1	2	3	4	5	6

In the past week, how bothersome have these symptoms been? (Please circle the number that applies)

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
5. Low back and/or buttock pain.....	1	2	3	4	5	6
6. Leg pain.....	1	2	3	4	5	6
7. Numbness or tingling in leg and/or foot.....	1	2	3	4	5	6
8. Weakness in leg and/or foot (such as difficulty lifting foot).....	1	2	3	4	5	6

9. Generally speaking, are your symptoms getting better or worse? (Fill in one circle)

- Getting much better Getting somewhat better Staying about the same
 Getting somewhat worse Getting much worse

The following questions are regarding what you expect from your treatment of your Back/Leg or Neck/Arm Pain.

As a result of my treatment, I expect...	Not Likely	Slightly Likely	Somewhat Likely	Very Likely	Extremely Likely
1. ...complete pain relief.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. ...moderate pain relief.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. ...to be able to do more everyday household or yard activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. ...to sleep more comfortably.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. ...to be able to go back to my usual job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. ...to be able to do more sports, to biking, or go for long walks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How important is...	Not Important	Slightly Important	Somewhat Important	Very Important	Extremely Important
7. ...complete pain relief?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. ...being able to do more everyday activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. ...being able to sleep more comfortably?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. ...being able to return to my usual job?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. ...being able to do more recreational activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. If you had to spend the rest of your life with your back condition as it is right now, how would you feel?
- | | | |
|--|---|---|
| <input type="radio"/> Extremely dissatisfied | <input type="radio"/> Very Dissatisfied | <input type="radio"/> Neutral |
| <input type="radio"/> Somewhat Satisfied | <input type="radio"/> Very Satisfied | <input type="radio"/> Extremely Satisfied |
-

HEALTH STATUS QUESTIONNAIRE (SF-36) Page 1 of 2

The following questions refer to your health in general, including, but not limited to, your back or neck.

1. In general, would you say your health is: (mark only one)

- Excellent Very Good Good Fair Poor

2. **Compared to one year ago**, how would you rate your health in general **now**? (mark only one)

- Much better than 1 year ago Somewhat better than 1 year ago About the same as 1 year ago Somewhat worse than 1 year ago Much worse than 1 year ago

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? (Fill in only one circle on each line.)

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited
3. Vigorous activities such as running, lifting heavy objects or participating in strenuous sports.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling or golf.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Lifting or carrying groceries.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Climbing several flights of stairs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Climbing one flight of stairs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Bending, kneeling, or stooping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Walking more than a mile .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Walking several blocks .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Walking one block .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Bathing or dressing yourself	<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**? (Fill in only one circle on each line.)

	Yes	No
13. Cut down on the amount of time you spent on work or other activities.	<input type="radio"/>	<input type="radio"/>
14. Accomplished less than you would like.	<input type="radio"/>	<input type="radio"/>
15. Were limited in the kind of work or other activities.	<input type="radio"/>	<input type="radio"/>
16. Had difficulty performing the work or other activities (e.g. took extra effort)	<input type="radio"/>	<input type="radio"/>

During the **past 4 weeks**, have you had any of the following problems with your regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Fill in only one circle on each line.)

	Yes	No
17. Cut down the amount of time you spent on work or other activities?	<input type="radio"/>	<input type="radio"/>
18. Accomplished less than you would like?	<input type="radio"/>	<input type="radio"/>
19. Didn't do work or other activities as carefully as usual?	<input type="radio"/>	<input type="radio"/>

HEALTH STATUS QUESTIONNAIRE (SF-36) Page 2 of 2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (mark only one)
 Not at all Slightly Moderately Quite a bit Extremely
21. How much **bodily** pain have you had during the **past 4 weeks**? (mark only one)
 None Very Mild Mild Moderate Severe Very Severe
22. During the **past 4 weeks** how much did **pain** interfere with your normal work (including both work outside the home and housework)? (mark only one)
 Not at all A little bit Moderately Quite a bit Extremely

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 time **during the past 4 weeks**... (Fill in only one circle on each line.)

	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
23. Did you feel full of pep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. Have you been a very nervous person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Did you feel full of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Have you been a happy person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

32. 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 and relatives, etc.)? (mark only one)

All of the time Most of the time Some of the time A little of the time None of the time

How **TRUE** or **FALSE** is **each** of the following statements for you? (Fill in only one circle on each line.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. I am as healthy as anybody I know.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. I expect my health to get worse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. My health is excellent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

OSWESTRY QUESTIONNAIRE

The following questions will give us information as to how your back or leg pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the answer which applies to you. We realize you may consider that two of the statements in any one section relate to you. Please just give the answer which most clearly describes your problem.

Pain Intensity (mark only one)

0. I have no pain at this moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.) (mark only one)

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

Lifting (mark only one)

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

Walking (mark only one)

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

Sitting (mark only one)

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

Standing (mark only one)

0. I can stand as long as I want without extra pain.
1. I can stand as long as I want, but it gives me extra pain.
2. Pain prevents me from standing for more than one hour.
3. Pain prevents me from standing for more than 1/2 hour.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Sleeping (mark only one)

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

Sex Life (mark only one)

0. My sex life is normal and causes no extra pain.
1. My sex life is normal, but causes some extra pain.
2. My sex life is nearly normal, but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Social Life (mark only one)

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

Traveling (mark only one)

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

HISTORY:

1. Is this an unresolved spinal litigation case? Yes No
If yes, please answer the following:
a. Is this the result of a motor vehicle accident? Yes No
b. Is this the result of a personal injury? Yes No
c. Other, please describe: _____
2. How long ago did your **current** back/neck symptoms begin?
 Less than two weeks ago Between two and eight weeks ago
 Between eight and twelve weeks ago Three months to six months ago
 Between six and twelve months ago More than twelve months ago
3. Have you had back/neck symptoms **before** your current episode?
 No Yes, one episode Yes, two or more episodes
4. How much work did you miss because of your worst **prior** episode?
 None 1 day to 2 weeks Between 2 and 4 weeks
 Between 4 and 12 weeks Between 12 and 24 weeks More than 24 weeks
5. Have you had **previous** back/neck surgery?
 No Yes; How many? _____
6. If so, did you return to work?
 No Yes, with limitations Yes, with no limitations
 Never stopped working Did not work prior to surgery
7. Which health care provider(s) have you used for your **current** condition? (Mark all that apply)
 Acupuncturist Chiropractor Emergency Room Internist
 General Practitioner Immediate Care Clinic Massage Therapist Neurosurgeon
 Nurse Practitioner Osteopath Orthopedic Surgeon Pain Clinic
 Physical Therapist Rheumatologist Work Hardening Other: _____
-

PAIN OR MUSCLE RELAXANT MEDICATION REGIMEN

During the last week, how often have you taken the following for your back/leg pain or neck/arm pain:

8. Non-Narcotic medication (such as aspirin, Tylenol, Motrin, Vioxx, Celebrex)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all
9. Weak narcotic medication (such as Tylenol #3, Darvocet N-100, Darvon, Vicodin)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all
10. Strong narcotic medication (such as Percodan, Percocet, Morphine, Demerol)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all

11. Muscle Relaxant medication (such as Flexeril, Parafon Forte, Robaxin)

- 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all

WORK STATUS:

1. Are you currently working? Yes No
2. If you are currently working, please answer the following:
- a. Occupation: _____
- b. Full Time Part Time
 Full Duty Light Duty
- c. If you are working less than **Full Time** or **Full Duty**, is this because of the problems with your back/neck?
 Yes No
3. If you are not currently working, answer the following:
- a. Are you not working because of problems with your back/neck? Yes No
- b. Retired
- c. Not Currently Employed
4. Highest level of education attained: < High School Associates Degree Masters Degree
 High School Bachelors Degree Professional Degree
5. When did you stop working?
- Less than one week ago
 More than one week but less than three months ago
 More than three months but less than six months ago
 More than six months but less than one year ago
 One to two years ago
 More than two years ago
 Never employed
 Currently working
6. Is your current job the same as when your back/neck problems began?
- Yes, exact same job.
 No, job changed due to back problems.
 Yes, but job was lightened due to back problems.
 No, job changed for reasons other than back.
 Not currently working.
7. How long have you been at current job?
- Less than six months Six to 12 months More than 12 months Not currently working
8. How much sitting does your job involve?
- 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. How much standing/walking does your job involve?
- 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

10. How often do you lift 25 lbs. on job?
 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
11. How often do you lift 50 lbs. on job?
 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
12. Is your job physically demanding?
 Extremely Very much Quite a bit Somewhat A little Not at all
13. Is your job stressful?
 Extremely Very much Quite a bit Somewhat A little Not at all
14. How much do you enjoy your job?
 Extremely Very much Quite a bit Somewhat A little Not at all
15. How much do you like your co-workers?
 Extremely Very much Quite a bit Somewhat A little Not at all
16. How much do you like your supervisor?
 Extremely Very much Quite a bit Somewhat A little Not at all
17. Other sources of income (mark all that apply)
 Another income Disability State support
 Other income Social Security No other income
18. Your opinion of fault (mark all that apply)
 Own fault Another fault Employer fault
 Co-worker fault No fault
19. Financial difficulties due to back condition?
 None at all Only a little Some A lot
20. Are you on, or planning to apply for Social Security?
 No Already on it Applied for it Planning to apply
21. Are you on, or planning to apply for Disability?
 No Already on it Applied for it Planning to apply
22. Are you on, or planning to apply for Worker's Compensation?
 No Already on it Applied for it Planning to apply
23. Are you on, or planning to apply for other program?
 Other program description _____
 No Already on it Applied for it Planning to apply

 Physician Signature

 Date

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