

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ HEIGHT: \_\_\_\_\_ FT. \_\_\_\_\_ IN. WEIGHT \_\_\_\_\_ LBS

**A.** 1. Internist or family doctor name and address: \_\_\_\_\_

2. Chief complaint  Neck pain Arm:  Pain  Numbness  Weakness  
(check all that apply)  Back pain Leg:  Pain  Numbness  Weakness  
 Other: \_\_\_\_\_

3. Your age: \_\_\_\_\_ Years \_\_\_\_\_ Months

4. Your sex:  Male  Female

5. How long has the pain (or your problem) been present? \_\_\_\_\_

6. Has your problem worsened recently?  No  Yes – How recently? \_\_\_\_\_

7. What started the pain (or problem)? \_\_\_\_\_

**B. For patients with BACK OR LEG pain, numbness, or weakness:**

(If you are seeing the doctor for neck pain, please ask for the Cervical questionnaire.)

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

Back 0%, Leg 100%  Back 10%, Leg 90%  Back 25%, Leg 75%

Back 40%, Leg 60%  Back 50%, Leg 50%  Back 65%, Leg 40%

Back 75%, Leg 25%  Back 90%, Leg 10%  Back 100%, Leg 0%

2. There is:  No Leg pain  Leg 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 65%, 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:**  Buttock  Thigh-front  Thigh-back  Calf  Foot

**Left:**  Buttock  Thigh-front  Thigh-back  Calf  Foot

3. There is:  No weakness of the legs  Weakness of the (check the following):

**Right:**  Thigh  Calf  Ankle  Foot  Big toe

**Left:**  Thigh  Calf  Ankle  Foot  Big toe

4. There is:  No numbness of the legs  Numbness of the (check the following):

**Right:**  Thigh  Calf  Foot

**Left:**  Thigh  Calf  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 ON TO THE NEXT PAGE**

- C.** 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.

- |                          |                          |                            |                          |                          |   |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---|
| <b>Neck</b>              | <b>Back</b>              |                            | <b>Neck</b>              | <b>Back</b>              |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy, exercise | <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | Massage & ultrasound       | <input type="checkbox"/> | <input type="checkbox"/> | Narcotic medication   |
| <input type="checkbox"/> | <input type="checkbox"/> | Traction                   | <input type="checkbox"/> | <input type="checkbox"/> | Epidural steroid injections ___times which<br>relieved the pain for (how long?) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Manipulation               |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | TENS unit                  | <input type="checkbox"/> | <input type="checkbox"/> | Trigger point injections ___times which<br>relieved the pain for (how long?) _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injections        |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Braces                     | <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 New York)	Treatments

**D. MEDICAL HISTORY**

Please 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"/> Loose, capped,<br>missing, or chipped<br>teeth |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Blood clot in lung           | <input type="checkbox"/> Serious injuries:<br>_____                     |
| <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Stomach ulcers               |   |
| <input type="checkbox"/> Ulcers or hiatus hernia | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Glasses<br>or contact lenses |   |
| <input type="checkbox"/> Dentures/Bridges        | <input type="checkbox"/> Problems with hearing |   |   |
| <input type="checkbox"/> Other: _____            |  |   |   |

- E. SURGICAL HISTORY:** Previous surgeries- list procedure, surgeon, and date.       None

OPERATION	SURGEON	DATE

- F. MEDICATIONS YOU TAKE:**       None

\_\_\_\_\_

\_\_\_\_\_

**G. ALLERGIES TO MEDICATIONS:**  No known drug allergies

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

**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. SOCIAL HISTORY**

1. Work status:  Homemaker  Retired  Disabled  On leave  
 Unemployed  Working: \_\_ Full time \_\_ Part time  
Occupation: \_\_\_\_\_
2. Marital status:  Married  Single  Co-habiting  
 Widowed  Divorced
3. Number of living children: \_\_\_\_\_
4. I live:  Alone  With: \_\_\_\_\_
5. 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).
6. Alcohol:  Never or rare  
 Social  Frequently drunk (more than twice a week)  
 Alcoholic  Recovering alcoholic
7. Drug use/abuse:  Never  Currently  In the past
8. Because of this spine problem, I have filed or plan to file:  
 A lawsuit  A Worker’s Compensation claim  
 Neither a lawsuit nor a Worker’s Compensation claim

**J. REVIEW OF SYSTEMS**

1. Do you have any problems with your **HEART** or **CIRCULATION**? Check all that apply  
 Heart murmur or Mitral Valve Prolapse  Irregular Heartbeat  
 Difficulty with Stairs (due to shortness of breath)  Sleeping on more than one pillow  
 Waking at night with shortness of breath  Ankle Swelling  
 Shortness of breath at rest or exercising  Chest pain at rest or exercising

If yes, please explain: \_\_\_\_\_

2. Do you have any problems with your **LUNGS** or **BREATHING**? Check all that apply

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Pneumonia           |
| <input type="checkbox"/> Bronchitis                  | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Cough or Coughing up phlegm | <input type="checkbox"/> Shortness of breath |

If yes, please explain: \_\_\_\_\_

3. Do you have any problems with your **BLOOD**? Check all that apply

- |   |  |
|---|--|
| <input type="checkbox"/> Bleeding tendency or easy bruising | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Blood transfusions                 |  |

If yes, please explain: \_\_\_\_\_

4. Do you have any problems with your **NERVES, MUSCLES** or **BONES**? Check all that apply

- |   |  |
|---|--|
| <input type="checkbox"/> Fainting spells                | <input type="checkbox"/> Muscle weakness     |
| <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Dizziness           |
| <input type="checkbox"/> Double vision                  | <input type="checkbox"/> Loss of sensation   |
| <input type="checkbox"/> Paralysis or weakness of limbs | <input type="checkbox"/> Loss of balance     |
| <input type="checkbox"/> Loss of coordination           | <input type="checkbox"/> Muscle wasting      |
| <input type="checkbox"/> Head, neck, or back injury     | <input type="checkbox"/> Psychiatric illness |
| <input type="checkbox"/> Extreme nervousness or anxiety |  |

If yes, please explain: \_\_\_\_\_

Are you pregnant?       Yes    No      Date of last menstrual period: \_\_\_\_\_

**MY PAIN/DISCOMFORT IS (circle number)**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
No pain	Slight	Mild	Moderate	Severe	Excruciating	Pain as bad as it could be				

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

**PLEASE GO ON TO THE NEXT PAGE**

## OSWESTRY DISABILITY INDEX 2.0

**Please read instructions:** Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

### **Section 1 – 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

### **Section 2 – Personal care (Washing, Dressing, etc.)**

- I can look after myself normally without causing extra pain
- I can look after myself normally but it 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, I wash with difficulty and stay in bed

### **Section 3 – 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.

### **Section 4 – Walking**

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ 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.

### **Section 5 – 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 ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

### **Section 6 – Standing**

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### **Section 7 – 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.

### **Section 8 – 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.

### **Section 9 – 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 on 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.

### **Section 10 – Travel**

- 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 short necessary journeys under 30 minutes.
- Pain prevents me traveling except to receive treatment.