Physical Medicine & Rehabilitation

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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**

Why are you being seen?_____

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

_____

_____

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

_____

What started the pain (or problem)? _____

_____

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

(If you are seeing the doctor for back or leg pain, go to "**B"**)

1. What % of your pain is neck pain and what % is arm pain? _____ % NECK _____% ARM

2. Arm pain (if present) _____% Right Arm _____% Left Arm
   The arm pain is present in these locations: (circle all that apply)

   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 or 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 or 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. Are there any difficulty picking up small objects like coins or buttoning buttons? YES or NO
8. Is there a problem with balance or tripping frequently? YES or NO
9. Do you get headaches in the back of the head? YES or NO

END OF NECK QUESTIONS – PLEASE GO TO "D"

B. 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?
   _____ % BACK _____% LEG/BUTTOCK

2. Leg pain (if present) _____% Right Leg _____% Left Leg
   The leg pain is present in these locations: (circle all that apply)

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 (circle 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 (circle 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 TO "D"

C. ★★★ 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		Neck	Back	
		Physical therapy, exercise			Anti-inflammatory medications
		Massage & ultrasound			Narcotic medication
		Traction			Epidural steroid injections _____ times which
		Manipulation			relieved the pain for (how long)? _____
		Tens Unit			Trigger point injections _____ times which
		Shoulder injections			relieved the pain for (how long)?_____
		Braces			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	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								
Myelogram								
CT Scan								
MRI								
EMGs								
Bone Scan								

D. REVIEW OF SYSTEMS: Circle all that apply

Reading glasses
Change of vision
Loss of hearing
Ear pain
Hoarseness
Nosebleeds
Difficulty swallowing
Morning cough
Shortness of breath
Fever or chills
Heart or chest pain

Abnormal heartbeat
Swollen ankles
Calf cramps w/ walking
Poor appetite
Toothache
Gum trouble
Nausea or vomiting
Stomach pain
Ulcers
Frequent belching
Frequent diarrhea

Frequent Constipation
Hemorrhoids
Frequent urination
Burning on urination
Difficulty starting urination
Get up more than once every night to urinate
Frequent headaches
Blackouts
Seizures
Frequent rash

Hot or cold spells
Recent weight change
Nervous exhaustion
Women only:
Irregular periods
Vaginal discharge
Frequent spotting
Other_____
_____
_____
_____

E. MEDICAL HISTORY: Circle all that apply. ____ None apply

Heart attack
Heart failure
High blood pressure
Osteoarthritis
Rheumatoid arthritis
Ankylosing spondylitis
Gout
Osteoporosis

Diabetes
Stroke
Seizures
Mental illness
Kidney stones
Kidney failure
Cancer
Alcoholism

Lung disease
HIV
AIDS
Tuberculosis
Asthma
Blood clot in leg
Blood clot in lung
Stomach ulcers

Liver trouble
Hepatitis
Thyroid trouble
Bleeding disorders
Anemia
Serious injuries (explain)
_____
Other:_____

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

OPERATION	SURGEON	DATE

G. FAMILY HISTORY: Circle all that apply. ____ None apply

Stroke
Heart trouble
High blood pressure
Diabetes

Arthritis
Gout
Seizures
Spine problems

Mental illness
Kidney trouble or stones
Cancer
Bleeding disorders

Alcoholism
Other:_____
_____
_____

H. MEDICATIONS YOU TAKE: ___ None

_____

_____

I. ALLERGIES TO MEDICATIONS:____No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other

J. SOCIAL HISTORY:

1. Work status: Homemaker Retired Disabled On leave
   Unemployed Working: ____Full time ____ Part time
   Occupation:_____

2. Marital status: Married Single Co-habitating
   Widowed Divorced

3. Number of living children: _____

4. I live: With:_____ Alone

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 overuse/abuse: Never Currently In the past

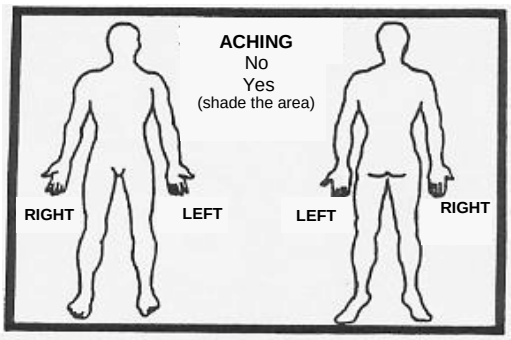
8. Because of this spine problem, I have filed or plan to file:
   ⋯ A lawsuit ⋯ A Worker's Compensation claim
   ⋯ Neither a lawsuit or Worker's Compensation claim

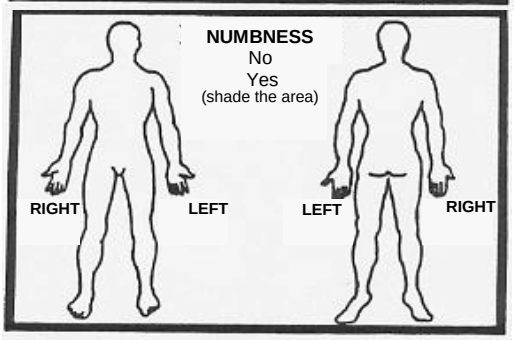
MY PAIN / DISCOMFORT IS (circle number)

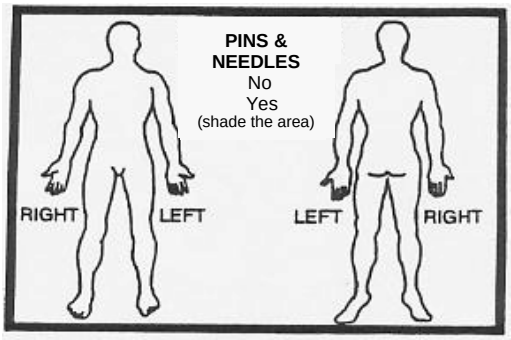
0 1 2 3 4 5 6 7 8 9 10

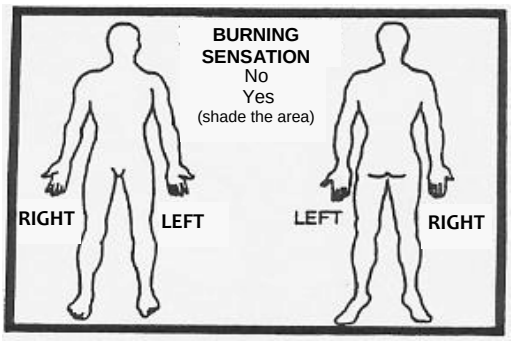
No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

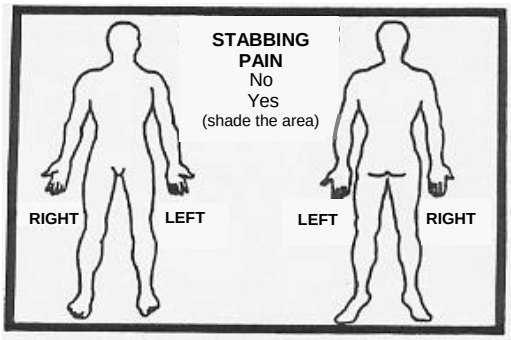
_____ _____
Patient Signature Date











Functional History

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

Tub bench:
Shower chair
Bedside commode

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 **<u>one</u>** 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 <u>Back/Leg or Neck/Arm Pain</u>.

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

How important is…	**Not Important**	**Slightly Important**	**Somewhat Important**	**Very Important**	**Extremely Important**
7. …complete pain relief?	❍	❍	❍	❍	❍
8. …being able to do more everyday activities?	❍	❍	❍	❍	❍
9. …being able to sleep more comfortably?	❍	❍	❍	❍	❍
10. ..being able to return to my usual job?	❍	❍	❍	❍	❍
11. ..being able to do more recreational activities?	❍	❍	❍	❍	❍

12. If you had to spend the rest of your life with your back condition as it is right now, how would you feel?

❍ Extremely dissatisfied ❍ Very Dissatisfied ❍ Neutral
❍ Somewhat Satisfied ❍ Very Satisfied ❍ Extremely Satisfied

HEALTH STATUS QUESTIONNAIRE (SF-36)

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 <u>one year ago</u>,** 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.	❍	❍	❍
4. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling or golf.	❍	❍	❍
5. Lifting or carrying groceries.	❍	❍	❍
6. Climbing **several** flights of stairs.	❍	❍	❍
7. Climbing **one** flight of stairs.	❍	❍	❍
8. Bending, kneeling, or stooping.	❍	❍	❍
9. Walking **more than a mile**.	❍	❍	❍
10. Walking **several blocks**.	❍	❍	❍
11. Walking **one block**.	❍	❍	❍
12. Bathing or dressing yourself	❍	❍	❍

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.	❍	❍
14. **Accomplished less** than you would like.	❍	❍
15. Were limited in the **kind** of work or other activities.	❍	❍
16. Had difficulty performing the work or other activities (e.g. took extra effort)	❍	❍

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?	❍	❍
18. **Accomplished less** than you would like?	❍	❍
19. Didn't do work or other activities as **carefully** as usual?	❍	❍

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?	❍	❍	❍	❍	❍	❍
24. Have you been a very nervous person?	❍	❍	❍	❍	❍	❍
25. Have you felt so down in the dumps that nothing could cheer you up?	❍	❍	❍	❍	❍	❍
26. Have you felt calm and peaceful?	❍	❍	❍	❍	❍	❍
27. Did you feel full of energy?	❍	❍	❍	❍	❍	❍
28. Have you felt downhearted and blue?	❍	❍	❍	❍	❍	❍
29. Did you feel worn out?	❍	❍	❍	❍	❍	❍
30. Have you been a happy person?	❍	❍	❍	❍	❍	❍
31. Did you feel tired?	❍	❍	❍	❍	❍	❍

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.	❍	❍	❍	❍	❍
34. I am as healthy as anybody I know.	❍	❍	❍	❍	❍
35. I expect my health to get worse.	❍	❍	❍	❍	❍
36. My health is excellent.	❍	❍	❍	❍	❍

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 mores 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.

BACK AND LEG PAIN QUESTIONNAIRE

This form is for the purpose of collecting back pain and leg pain information from you. Answer **every** question by filling in the appropriate circle. If you are unsure about how to answer a question, please give the best answer you can. Mark only **one** answer for each question.

BACK PAIN

1. On the scale of 0 to 10, mark your intensity of **back** pain discomfort with 0 being **no pain** and 10 being p**ain as bad as it could be.**

No	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad**
Pain	O	O	O	O	O	O	O	O	O	O	O	**As It Could Be**

2. On the scale of 0 to 10, mark how often you had **back** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of	0	1	2	3	4	5	6	7	8	9	10	**All Of The**
The Time	O	O	O	O	O	O	O	O	O	O	O	**Time**

LEG PAIN

1. On the scale of 0 to 10, mark your intensity of **leg** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad**
Pain	O	O	O	O	O	O	O	O	O	O	O	**As It Could Be**

2. On the scale of 0 to 10, mark how often you had **leg** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of	0	1	2	3	4	5	6	7	8	9	10	**All Of The**
The Time	O	O	O	O	O	O	O	O	O	O	O	**Time**

HISTORY:

1. Is this an unresolved spinal litigation case? O Yes O No
   If yes, please answer the following:
   a. Is this the result of a motor vehicle accident? O Yes O No
   b. Is this the result of a personal injury? O Yes O No
   c. Other, please describe: _____

2. How long ago did your **current** back/neck symptoms begin?
   O Less than two weeks ago O Between two and eight weeks ago
   O Between eight and twelve weeks ago O Three months to six months ago
   O Between six and twelve months ago O More than twelve months ago

3. Have you had back/neck symptoms **before** your current episode?
   O No O Yes, one episode O Yes, two or more episodes

4. How much work did you miss because of your worst **prior** episode?
   O None O 1 day to 2 weeks O Between 2 and 4 weeks
   O Between 4 and 12 weeks O Between 12 and 24 weeks O More than 24 weeks

5. Have you had **previous** back/neck surgery?
   O No O Yes; How many? _____

6. If so, did you return to work?
   O No O Yes, with limitations O Yes, with no limitations
   O Never stopped working O Did not work prior to surgery

7. Which health care provider(s) have you used for your **current** condition? (Mark all that apply)
   O Acupuncturist O Chiropractor O Emergency Room O Internist
   O General Practitioner O Immediate Care Clinic O Massage Therapist O Neurosurgeon
   O Nurse Practitioner O Osteopath O Orthopedic Surgeon O Pain Clinic
   O Physical Therapist O Rheumatologist O Work Hardening O 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)
   O 3 or more times a day O Once or twice a day O Once every couple of days
   O Once a week O Not at all

9. Weak narcotic medication (such as Tylenol #3, Darvocet N-100, Darvon, Vicodin)
   O 3 or more times a day O Once or twice a day O Once every couple of days
   O Once a week O Not at all

10. Strong narcotic medication (such as Percodan, Percocet, Morphine, Demerol)
    O 3 or more times a day O Once or twice a day O Once every couple of days
    O Once a week O Not at all

11. Muscle Relaxant medication (such as Flexeril, Parafon Forte, Robaxin)
    O 3 or more times a day O Once or twice a day O Once every couple of days
    O Once a week O Not at all

WORK STATUS:

1. Are you currently working? O Yes O No

2. If you are currently working, please answer the following:
    a. Occupation:_____

    b. O Full Time O Part Time
       O Full Duty O Light Duty

    c. If you are working less than **Full Time** or **Full Duty**, is this because of the problems with your back/neck?
       O Yes O No

3. If you are not currently working, answer the following:
    a. O Are you not working because of problems with your back/neck? O Yes O No
    b. O Retired
    c. O Not Currently Employed

4. Highest level of education attained: O < High School O Associates Degree O Masters Degree
    O High School O Bachelors Degree O Professional Degree

5. When did you stop working?
    O Less than one week ago
    O More than one week but less than three months ago
    O More than three months but less than six months ago
    O More than six months but less than one year ago
    O One to two years ago
    O More than two years ago
    O Never employed
    O Currently working

6. Is your current job the same as when your back/neck problems began?
    O Yes, exact same job.
    O No, job changed due to back problems.
    O Yes, but job was lightened due to back problems.
    O No, job changed for reasons other than back.
    O Not currently working.

7. How long have you been at current job?
    O Less than six months O Six to 12 months O More than 12 months O Not currently working

8. How much sitting does your job involve?
    O All of the time O Most of the time O A good bit of the time
    O Some of the time O A little of the time O None of the time

9. How much standing/walking does your job involve?
    O All of the time O Most of the time O A good bit of the time
    O Some of the time O A little of the time O None of the tim

10. How often do you lift 25 lbs. on job?
O All of the time O Most of the time O A good bit of the time
O Some of the time O A little of the time O None of the time

11. How often do you lift 50 lbs. on job?
O All of the time O Most of the time O A good bit of the time
O Some of the time O A little of the time O None of the time

12. Is your job physically demanding?
O Extremely O Very much O Quite a bit O Somewhat O A little O Not at all

13. Is your job stressful?
O Extremely O Very much O Quite a bit O Somewhat O A little O Not at all

14. How much do you enjoy your job?
O Extremely O Very much O Quite a bit O Somewhat O A little O Not at all

15. How much do you like your co-workers?
O Extremely O Very much O Quite a bit O Somewhat O A little O Not at all

16. How much do you like your supervisor?
O Extremely O Very much O Quite a bit O Somewhat O A little O Not at all

17. Other sources of income (mark all that apply)
O Another income O Disability O State support
O Other income O Social Security O No other income

18. Your opinion of fault (mark all that apply)
O Own fault O Another fault O Employer fault
O Co-worker fault O No fault

19. Financial difficulties due to back condition?
O None at all O Only a little O Some O A lot

20. Are you on, or planning to apply for Social Security?
O No O Already on it O Applied for it O Planning to apply

21. Are you on, or planning to apply for Disability?
O No O Already on it O Applied for it O Planning to apply

22. Are you on, or planning to apply for Worker's Compensation?
O No O Already on it O Applied for it O Planning to apply

23. Are you on, or planning to apply for other program?
Other program description _____
O No O Already on it O Applied for it O Planning to apply

_____ _____
Physician Signature Date

NECK AND ARM PAIN QUESTIONNAIRE

This form is for the purpose of collecting Neck pain and Arm pain information from you. Answer **every** question by filling in the appropriate circle. If you are unsure about how to answer a question, please give the best answer you can. Mark only **one** answer for each question.

NECK PAIN

1. On the scale of 0 to 10, mark your intensity of **neck** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be.**

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad As It Could Be**

2. On the scale of 0 to 10, mark how often you had **neck** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	**All Of The Time**

ARM PAIN

1. On the scale of 0 to 10, mark your intensity of **arm** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Pain As Bad As It Could Be**

2. On the scale of 0 to 10, mark how often you had **arm** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	**All Of The Time**

Neck Disability Index

Please read: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and 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 related to you, but please just mark the box which most closely describes your problem.

Patient Signature_____

Date:_____/____/_____

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 causes extra pain
- ☐ 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 very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want to with moderate pain in my neck
- ☐ I can’t read as much as I want because of pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5 – Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7 – Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

Section 8 – Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I cannot drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I cannot drive my car at all

Section 9 – Sleeping

- I have no problem sleeping
- My sleep is slightly disturbed (less than 1hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-6 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

Section 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some pain in my neck
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- I am able to engage in few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I cannot do any recreation activities at all

CURRENT SYMPTOMS

1. Please indicate those areas that have bothered you or limited your function in the **past week**.
(Circle **all that apply**)

Shoulder	Head	Hip
Arm above the elbow	Neck	Leg above the knee
Elbow	Upper back	Knee
Arm below the elbow	Middle back	Leg below the knee
Wrist/hand	Lower back	Ankle/foot
	Buttocks	

In the **past week**, how often have you suffered:

Put an "X" in **one** box on each line	**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**
2. Neck pain?						
3. Arm pain?						
4. Numbness or tingling in arm and/or hand?						
5. Weakness in arm and/or hand?						
6. Low back and/or buttocks pain?						
7. Leg pain?						
8. Numbness or tingling in leg and/or foot?						
9. Weakness in leg and/or foot?						

In the **past week**, how bothersome have these symptoms been?

Put an "X" in **one** box on each line	**Not at all bother-some**	**Slightly bother-some**	**Somewhat bother-some**	**Moderately bothersome**	**Very bother-some**	**Extremely bother-some**
10. Neck pain?						
11. Arm pain?						
12. Numbness or tingling in arm and/or hand?						
13. Weakness in arm and/or hand?						
14. Low back and/or buttocks pain?						
15. Leg pain?						
16. Numbness or tingling in leg and/or foot?						
17. Weakness in leg and/or foot?						

18. Generally speaking, are your symptoms getting better or worse? (Circle One)

Getting much better Getting somewhat better Staying about the same

Getting somewhat worse Getting much worse