

Lumbar Spine Initial Form - Twin Cities Orthopedics

STICKER FIELD

Date of Surgery: (MM/DD/YYYY)

		/			/				
--	--	---	--	--	---	--	--	--	--

What's patient's height?

	Feet			Inches
--	------	--	--	--------

What's patient's weight?

			Pounds
--	--	--	--------

Marking Instructions: Please FILL in the appropriate boxes or circles
Printing Instructions: Please Print in ALL CAPITAL letters & keep all letters within the box

Please select your surgeon from the list below:

- Paul J Crowe, MD
- Jeffrey C Dick, MD
- David C Holte, MD
- John E Sherman, MD



Race/Ethnicity (optional question): Please select one

- White
- Black or African-American
- Hispanic or Latino
- Asian
- American Indian and Alaska Native
- Native Hawaiian and Other Pacific Islander
- Other



Patient Demographics Information

Education Level: Please select one

- No schooling completed
- Less than 12th grade
- 12th grade, NO DIPLOMA
- High school DIPLOMA or the equivalent (for example: GED)
- Some college credit, but less than 1 year
- Associate degree (for example: AA, AS)
- Bachelor's degree (for example: BA, AB, BS)
- Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
- Professional degree (for example: MD, DDS, DVM, LLB, JD)
- Doctorate degree (for example: PhD, EdD)

Do you currently smoke cigarettes or use any other tobacco products ? (Mark one response.)

- Yes
- No, I quit smoking or using any other tobacco products less than 6 months ago.
- No, I quit smoking or using any other tobacco products more than 6 months ago.
- No, I have never smoked or used any other tobacco products . (If select this choice; GO TO NEXT PAGE)

How many years have you been smoking/using or did you smoke/use cigarettes or any other tobacco products?

Years

On average, how many packs of cigarettes/tobacco products do you or did you smoke each day?

- ¼ pack per day or less (5 cigarettes or less)
- ½ pack per day
- 1 pack per day
- 1 ½ packs per day
- 2 packs or more per day



Surgery History & Comorbidities

Have you ever had any “low back related spine surgery” previously?

- No. I have never had “low back related spine surgery” previously
- I had 1 surgery
- I had 2 surgeries
- I had 3 or more surgeries

Comorbidities:

YES **NO**

Do you have heart disease?

If you have heart disease, does it limit your activities?

Do you have lung disease?

If you have lung disease, does it limit your activities?

Do you have diabetes?

Do you have fibromyalgia?

Please answer each question by filling the circle that best describes your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed



Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

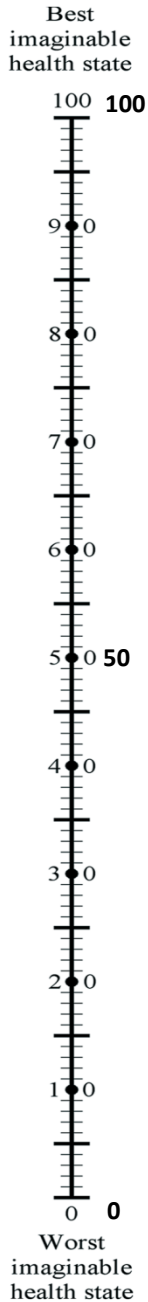
- I am not anxious or depressed
- I am moderately anxious and depressed
- I am extremely anxious or depressed

Please continue to the next page



To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked **100** and the worst state you can imagine is marked **0**.

We would like you to use this scale to determine how good or bad your own health is **today**, in your opinion. Please enter your health state score in the section on right side of the scale.



Health State Score (0-100)

--	--	--

Please enter your health state score above

© 1990 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group

Please continue to the next page



OSWESTRY DISABILITY INDEX (2.1a)

This questionnaire is designed to give us information about how your BACK (or LEG) trouble affects your ability to manage your daily life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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.

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, wash with difficulty and stay in bed.

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. ²
- 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.



4. Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than one mile.
- Pain prevents me walking more than a quarter 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.



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 half an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

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 half an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

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 sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

8. Sex life (If it is NOT applicable, please SKIP to the next question)

- 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.



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. sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

10. Traveling

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

ODI © Jeremy Fairbank, 1980. All Rights Reserved.

Please continue to the next and last questionnaire



VISUAL ANALOG PAIN SCALE – LOW BACK PAIN

Indicate the severity of your pain today by marking X in one circle that most applies to you.
See the example below:



Migraine Pain:

0 No Pain 10 Worst Possible Pain

Low Back Pain Questionnaire

BACK PAIN:

0 No Pain 10 Worst Possible Pain

RIGHT LEG PAIN:

0 No Pain 10 Worst Possible Pain

LEFT LEG PAIN:

0 No Pain 10 Worst Possible Pain

HIP PAIN: If you had donor bone removed from iliac crest, describe your hip pain.

0 No Pain 10 Worst Possible Pain

