TWIN CITIES ORTHOPEDICS

Spine Pain Questionnaire

Patient Sticker

Patient Name: _____ Date: _____

Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What is the reason you are seeing the orthopedic surgeon:

☐ Evaluation and treatment ☐ 2nd opinion ☐ Disability rating

History of Current Problems.

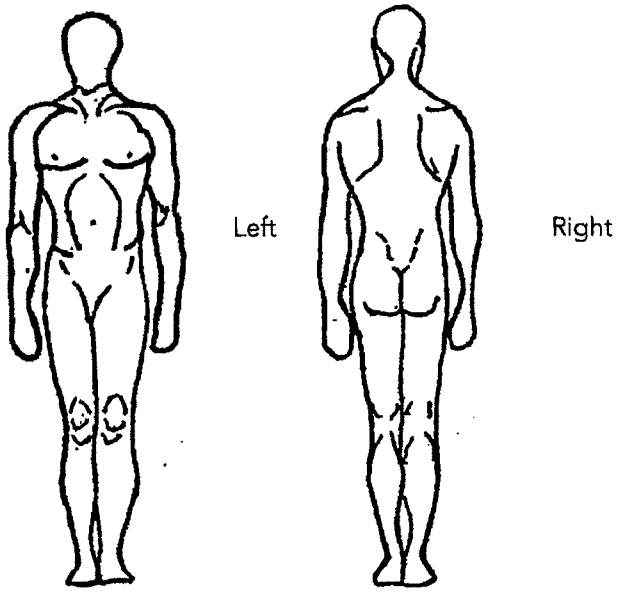
1. Date that your back or neck problems started? _____
2. Have you had a similar problem in the past? ☐ No ☐ Yes If yes, when _____
   Please describe: _____
3. Is your current problem the result of a: ☐ No injury that you know of ☐ Work injury
   ☐ Motor vehicle accident ☐ Other injury If an injury, give **Date of Injury?** _____
4. Has litigation or claim for compensation been initiated? ☐ No ☐ Yes
5. Please briefly describe how your current back/neck and/or leg/arm problems first began:

_____

_____

Symptom (Pain) Diagram – Please use the diagrams below to indicate the area of your symptoms and the type of symptoms you are experiencing. Use the appropriate symbol. Include all affected areas.

Sharp Pain (///)
Pins/Needles (ooo)
Aching Pain (xxx)
Numbness (+++)
Burning (BBB)



Right Left Right

Front Back

How much of your problem is in your back or leg? **Back** _____ % + **Leg** _____ % = **100%**

If you have pain in your legs, which is worse: Right _____ Left _____ Equal _____

How much of your problem is in your neck or arm? **Neck** _____ % + **Arm** _____ % = **100%**

If you have pain in your arms, which is worse: Right _____ Left _____ Equal _____

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Description of Symptoms

Pain Scale: 0 = No Pain 10 = Worst Pain Possible

1. When my pain is at its worst, it is a _____ (Pick a number from the above pain scale).
2. When my pain is at its best, it is a _____ (Pick a number from the above pain scale).
3. Most of the time, my pain is a _____ (Pick a number from the above pain scale).
4. Have you noticed weakness in any muscles since your problem began? ☐ No ☐ Yes*
   *If yes, please describe: _____
5. How far do you estimate you can walk? _____ Feet or _____ Miles or ☐ Unlimited

Treatment

What medications are you currently taking for your pain? _____

_____

What medications have you taken in the past for your pain? _____

_____

List the physicians you have seen for this problem. _____

_____

How many times have you been treated by the following professionals?

Physical Therapist: _____. When? _____. Chiropractor: _____ When? _____

Have you had any of the following spinal treatments?

☐ Epidural Steroid Injections ☐ Trigger-Point Injections ☐ Facet Injections ☐ Other: _____

When? _____ When? _____ When? _____ When? _____

☐ Please list any surgeries you have had on your spine?

Date	Surgeon	Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any of the following tests or studies you have had and give the date they were done.

☐ X-Ray _____ ☐ CT Scan _____

☐ MRI Scan _____ ☐ EMG Test _____

☐ Discogram _____ ☐ Bone density _____

☐ Other _____ ☐ None of the above

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Back/Neck Pain Survey

Indicate the severity of your pain today by marking the appropriate lines below with a vertical line.

Back Pain Survey

BACK PAIN:

Check if not applicable ☐

RIGHT LEG PAIN:

Check if not applicable ☐

LEFT LEG PAIN:

Check if not applicable ☐

Neck Pain Survey

NECK PAIN:

Check if not applicable ☐

RIGHT ARM PAIN:

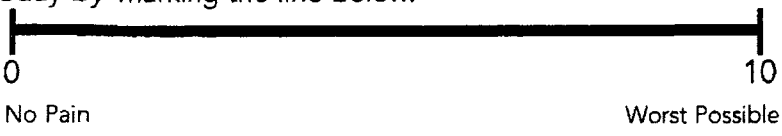
Check if not applicable ☐

LEFT ARM PAIN:

Check if not applicable ☐

Back/Neck Pain Survey

HIP PAIN: If you had donor bone removed from iliac crest, describe your hip pain today by marking the line below.



Check if not applicable ☐

TWIN CITIES ORTHOPEDICS

This survey asks for your views about your health. For each of the following questions, please mark an ☒ in the box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following questions are about activities you might do during a typical day. Does your **health now limit you** in these activities? If so, how much

	Yes, very limited	Yes, limited a little	No, not limited at all
a) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	☐ 1	☐ 2	☐ 3
b) Climbing several flights of stairs	☐ 1	☐ 2	☐ 3

3. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	All of the time	Most of the time	Some of the time	A little the time	None of the time
a) **Accomplished** less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) Were limited in the **kind** of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

4. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of emotional problems** (such as feeling depressed of anxious)?

	All of the time	Most of the time	Some of the time	A little the time	None of the time
a) Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) Did work or other activities less carefully than usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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

Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. 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 ...

	All of the time	Most of the time	Some of the time	A little the time	None of the time
a) have you felt calm or peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b) have you felt downhearted and depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Modified Oswestry Pain Questionnaire

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section one box that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I can manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no effect on my pain.

Section 2 - Personal Care

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself, and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased 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 off the floor, but I can manage light to medium weights if they are conveniently positioned on a table.
- ☐ I can only lift 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 (1 mile = 1.6 km).
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ 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 more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 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 increased pain.
- ☐ I have some pain while standing, but it does not increase my 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

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of pain.

Section 9 - Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the physician/therapist or hospital.

Section 10 - Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- ☐ Pain prevents me from performing anything but light duties.
- ☐ Pain prevents me from performing even light duties
- ☐ Pain prevents me from performing any job or homemaking chore.

Modified by permission of The Chartered Society of Physiotherapy from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy.* 1980;66:271-273

* 1 mile = 1.6 km