Orthopaedic Specialists of North Carolina

www.orthonc.com

Back and Neck Pain Questionnaire

Please print legibly in black ink. Answer only questions applicable to your condition. Leave other spaces blank.

Date you are filling out this form:

PERSONAL DATA

Name: **Medical Record #:**

Referring Physician: Age: ☐ Male ☐ Female

Height: Weight: Temp: E-mail address: _____

What is your primary problem? _____

How did it begin (check all that apply): ☐ Gradually ☐ Suddenly ☐ Woke-up with it

How long have these symptoms been present?_____ What started the pain/problem?:

☐ Fall: (how high ft) ☐ Twisting ☐ Bending ☐ Running ☐ Pushing

☐ Lifting: (how much lbs) ☐ Pulling ☐ Reaching ☐ Direct blow

☐ Motor Vehicle Accident ☐ Other:

Was this the result of an injury at: ☐ Work ☐ School ☐ Sports ☐ Unrelated

Is there/will there be legal action? ☐ No ☐ Yes What is the current status of this action?

Is there a Workers' Compensation claim pending/active? ☐ No ☐ Yes

Have you or will you hire a personal attorney? ☐ No ☐ Yes ☐ Undecided

Did you ever have to be hospitalized for your back/neck pain (other than for surgery)? ☐ No ☐ Yes

How many spine surgeries have you had?

Please list all spine surgeries:

Date Surgeon Location Type of procedure:

Date Surgeon Location Type of procedure:

Over the last year, have you tried ***physical therapy***? ☐ No ☐ Yes What did the therapy include (please list)?

Overall, did you find therapy helpful? ☐ No ☐ Yes

Have you tried ***lumbar epidural steroid injections***? ☐ No ☐ Yes

If yes, ***how many*** have been done over the last year? When was the last injection?

Overall, do you find the epidural steroid injections helpful? ☐ No ☐ Yes

If they are helpful to you, how long does the benefit last? Days Weeks Months

Over the last year, what ***pain medications*** have you tried, but are ***no longer taking***?

What ***pain medications*** are you ***currently taking***? Name/Dose/How many per day?

LIMITATIONS

Despite the treatments tried and medications being used, are you still limited by your back and/or leg pain?

☐ No ☐ Yes

What ***recreational*** activities would you like to do, but can't specifically because of your back and/or leg pain?

What ***social*** activities have you given up because of the pain?

For patients with NECK AND/OR ARM pain (For back or leg pain, skip to next page):

Does raising the arm bring on, or make worse, the pain in your ☐ arms ☐ neck?

Which condition best describes the percentage of pain in your neck vs. in your arms:

☐ 100% neck / 0% arms ☐ 75% neck / 25% arms ☐ 50% neck / 50% arms

☐ 25% neck / 75% arms ☐ 0% neck / 100 % arms

Please further define your ***arm pain*** : (for total of 100%)

My arm pain is % Right-sided My arm pain is % Left-sided

What do you do to ***relieve*** the pain? ☐ raise arm ☐ leaning forward ☐ lying down ☐ other (please explain)

Have you noticed difficulty in buttoning your buttons, dropping things, or change in your handwriting?

☐ No ☐ Yes

Do you have problems with balance, or trip frequently? ☐ No ☐ Yes

For patients with BACK AND/OR LEG PAIN:

Does walking bring on, or make worse, the pain in your ☐ legs ☐ low back?

How far can you ***comfortably walk***? blocks

Which condition best describes the percentage of pain in your back vs. in your legs:

☐ 100% back / 0% legs ☐ 75% back / 25% legs ☐ 50% back / 50% legs

☐ 25% back / 75% legs ☐ 0% back / 100 % legs

Please further define your ***leg pain*** : (for total of 100%)

My leg pain is % Right-sided My leg pain is % Left-sided

Which of the following make your pain ***worst***? (check one)

☐ walking ☐ standing ☐ sitting ☐ lying down

What do you do to ***relieve*** the pain? ☐ sitting ☐ leaning forward ☐ lying down ☐ other (please explain)

ASSOCIATED SYMPTOMS

Before we move on to describe the history of your pain, we have some questions directed at helping us to know whether your spinal nerves are being compressed and affecting other basic functions.

Do you have problems controlling your ***urination***? ☐ No ☐ Yes If yes, please describe your difficulties:

Do you have problems controlling your ***bowel movements***? ☐ No ☐ Yes If yes, please describe your difficulties:

Do you have ***numbness*** in the following areas? (check all that apply)

☐ Buttocks ☐ Perianal ☐ Back of upper thigh ☐ Vaginal ☐ Penile ☐ Scrotal

Does your pain/difficulty ***impair*** your ability to have sexual intercourse? ☐ No ☐ Yes

How is your ***appetite***? ☐ Good ☐ Bad

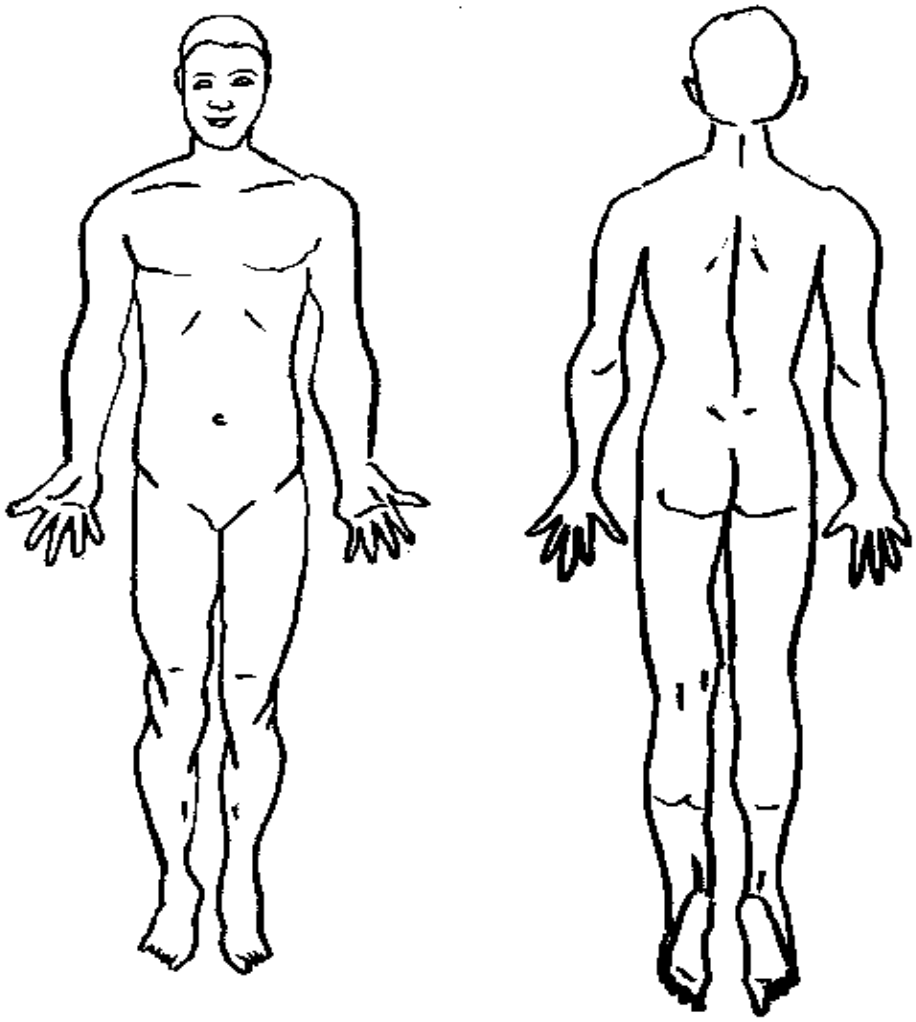
Do you regularly get ***fevers***? ☐ No ☐ Yes; ***Chills***? ☐ No ☐ Yes; N***ight sweats***? ☐ No ☐ Yes

Circle a number below on each line to indicate any problems you are experiencing with:

	None									Severe
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Poor sleep	1	2	3	4	5	6	7	8	9	10
Irritibility	1	2	3	4	5	6	7	8	9	10

PAIN DIAGRAM

Please note the orientation of the diagrams below and mark on them the exact spots where you are experiencing any of the following sensations on your own body (please use only the symbols listed):



= = = Numbness

O O O Pins and Needles

X X X X Burning

> > > > Aching

/ / / / Stabbing

● ● ● ● Other

(explain) _____

Place a vertical mark on the line below to indicate how bad your pain is today:

No Pain l----------l Very Severe Pain

WORK HISTORY AND LIMITATIONS

Are you currently working? ☐ No ☐ Yes If yes, how many days per month do you miss from work because of your pain: days If no, did you stop working because of your pain? ☐ No ☐ Yes

Current/Recent Employer: Date of Hire: Usual occupation:

Briefly describe your job:

Do/did you like your job? ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Hate it

Physical demands of your job:

☐ Very heavy (frequently lift >100 lbs) ☐ Light (frequently lift 15-30 lbs)

☐ Heavy (frequently lift >60 lbs) ☐ I use my hands to do repetitive motion type tasks

☐ Moderate (frequently lift >30 lbs) ☐ Sedentary (no lifting or repetitive motion tasks)

Work status ***today***: ☐ Regular duties ☐ On disability (date begun)

☐ Light or modified duties (date begun) ☐ On time loss (date begun)

What are your limitations at work? Cite specific duties or activities with which you have difficulty.

PAST MEDICAL HISTORY

Who is your primary care provider and where are they located?

When were you last seen for a general physical? Date

Do you have (or have you had) any of the following? (please check all that apply)

☐ myocardial infarction (heart attack) If so, what year?

☐ stroke ☐ stomach ulcers/ gastritis

☐ pulmonary embolus ☐ hepatitis if so, what year

☐ coronary artery disease ☐ kidney disease

☐ high blood pressure ☐ rheumatoid arthritis

☐ peripheral vascular disease (poor circulation of legs) ☐ lupus

☐ asthma ☐ HIV

☐ pneumonia, what year ☐ cancer

☐ other lung problems, describe ☐ Diabetes

☐ Others (please list):

PAST SURGICAL HISTORY

You've already listed spinal surgeries. Please list other surgeries (Procedures/Date)

During any of your surgeries including spine surgery:

Were there any major complications with anesthesia? ☐ No ☐ Yes

Were there any major bleeding or clotting complications? ☐ No ☐ Yes If yes, please describe:

Do you have a tendency to bleed easily? ☐ No ☐ Yes Do you bruise easily? ☐ No ☐ Yes

CURRENT MEDICATIONS

Please list ***all*** of your current medications (pain medications first): Medication/Dose/Frequency

Are you taking calcium and/or Vitamin D supplements?

MEDICATION ALLERGIES

Do you have any ***drug allergies***? ☐ No ☐ Yes If yes, please list the medicine and the reaction:

SOCIAL HISTORY

Married: ☐ No ☐ Yes # of children: Present occupation:

If not currently working, date last worked: If not currently working, reason stopped:

SMOKING HISTORY

Do you currently smoke tobacco products? ☐ No ☐ Yes How many total years?

How many packs do you/did you average per day? packs

If no, have you ever smoked tobacco products in the past? ☐ No ☐ Yes

When did you stop smoking? Month / Year

ALCOHOL HISTORY

Do you drink alcohol products? ☐ No ☐ Yes If yes, how many drinks per day? Per week?

Have you ever required medical treatment for your alcohol intake? ☐ No ☐ Yes

RECREATIONAL DRUGS

Do you use recreational drugs? ☐ No ☐ Yes If yes, please describe:

Family History

Does anyone in your family have a history of **heart disease, diabetes, lung problems, stroke, rheumatoid arthritis, back problems requiring surgery, or other.** Please list or circle:

REVIEW OF MEDICAL PROBLEMS

Do you have any other medical problems that have not already been listed? For example, consider problems with **heart, chest pain/tightness/pressure, lungs, shortness of breath, kidney, thyroid, pancreas, adrenal gland, diabetes, stomach ulcers, gastritis, arthritis, anemia, bone marrow, infections (tuberculosis, bladder infections, etc), epilepsy, stroke, depression, unusual stress at home or work, or other**

Please list below or write **NONE:**

1. 5.
2. 6.
3. 7.
4. 8.

The Neck Disability Index

Patient name: File# Date:

Please read instructions:
This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday 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.

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, for example, 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.
- ☐ 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 moderate 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 that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that 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 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 can't 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 can't 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 can't drive my car at all.

SECTION 9-SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs 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 neck pain at all.
- ☐ 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 recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly 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 (eg. washing, dressing)
- ☐ 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 can 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

Section 3: Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than 300 feet
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ 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 30 minutes
- ☐ 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 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

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 gives 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
- ☐ 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: Travelling
- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me 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