TOWN AND COUNTRY CROSSING ORTHOPEDICS

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SPINE PATIENT QUESTIONNAIRE (Cervical Attachment)

☛ Please answer all questions completely

☛ It is in your best interest and will assist Dr. Taylor with your care.

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Facilities: CT Partners of Chesterfield, MRI Partners of Chesterfield, Imaging Partners of Missouri, Pain and Rehabilitation Specialists of St. Louis, St. Louis Spine and Orthopedic Surgery Center.
You as a patient or employer of a patient have the right to refuse care at these facilities.
To all insurers, please notify any repricer you choose of Dr. Taylor's Disclosure provided in this document.

NAME:_____ DATE: _____

BIRTHDATE:_____/_____/_____ HEIGHT:_____FT._____IN. WEIGHT_____LBS

A. 1. Referring doctor name and full address:_____

_____

If not referred, how did you choose this office?_____

2. Internist or family doctor name and address:_____

_____

3. Chief complaint ☐ Neck pain Arm: ☐ Pain ☐ Numbness ☐ Weakness
(check all that apply): ☐ Back pain Leg: ☐ Pain ☐ Numbness ☐ Weakness Other_____
4. Your age:_____ Years _____ Months
5. Your sex: ☐ Male ☐ Female
6. How long has the pain (or your problem) been present?_____
7. Has your problem worsened recently? ☐ No ☐ Yes – How recently?_____

_____

8. What started the pain (or problem)?_____

_____

B. **For patients with NECK OR ARM pain, numbness or weakness:**
(If you are seeing the doctor for back or leg pain, go to "**C**")

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)
☐ Neck 0%, Arm 100% ☐ Neck 10%, Arm 90% ☐ Neck 25%, Arm 75% ☐ Neck 40%, Arm 60%
☐ Neck 50%, Arm 50% ☐ Neck 60%, Arm 40% ☐ Neck 75%, Arm 25% ☐ Neck 90%, Arm 10%
☐ Neck 100%, Arm 0%
2. There is: ☐ No arm pain ☐ Arm 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 60%, Left 40% ☐ Right 75%, Left 25% ☐ Right 90%, Left 10%
☐ Right 100%, Left 0%
b. The arm pain is present in the (check the following):
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 ☐ 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 ☐ 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. There (☐ is ☐ is no) difficulty picking up small objects like coins or buttoning buttons.
8. There (☐ is a ☐ is no) problem with balance or tripping frequently.
9. There are: (☐ Frequent ☐ Occasional ☐ No) headaches in the back of the head.

END OF NECK QUESTIONS – PLEASE GO TO "D"

_____ _____

Patients Signature Date

C. 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? (check appropriate box):
   ☐ Back 0%, Leg 100% ☐ Back 10%, Leg 90% ☐ Back 25%, Leg 75% ☐ Back 40%, Leg 60%
   ☐ Back 50%, Leg 50% ☐ Back 60%, Leg 40% ☐ Back 75%, Leg 25% ☐ Back 90%, Leg 10%
   ☐ Back 100%, Leg 0%
2. There is: ☐ No leg pain ☐ Leg pain 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 60%, 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 TO "D"

D. ★★★ 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 relieved the pain for (how long)?_____
☐	☐	Manipulation			
☐	☐	Tens Unit	☐	☐	Trigger point injections _____ times which relieved the pain for (how long)?_____
☐	☐	Shoulder injections			
☐	☐	Braces	☐	☐	Other:_____

5. List pain medications and dose taken for your spine problem: ☐ None

Medication	Dose

_____ _____

Patients Signature Date

6. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City (If not St. Louis)	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	☐	☐			

E. REVIEW OF SYSTEMS: Check all that apply. ☐ None 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_____

F. MEDICAL HISTORY: Check 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:_____

G. SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. ☐ None

OPERATION	SURGEON	DATE

H. FAMILY HISTORY: Check 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:_____

I. MEDICATIONS YOU TAKE: ☐ None

_____

_____

_____ _____

Patients Signature Date

J. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

K. 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: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
   ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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

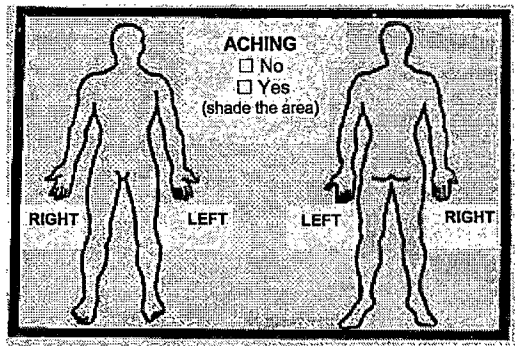
7. Drug overuse/abuse: ☐ Never ☐ Currently ☐ In the past

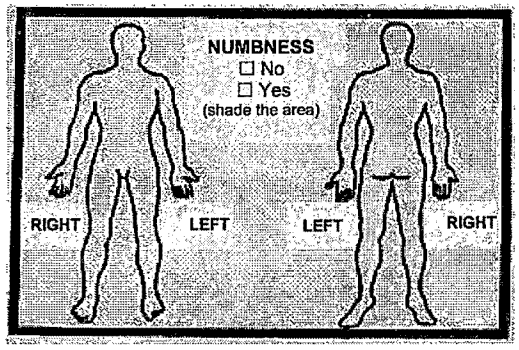
8. Because of this spine problem, I have filed or plan to file:
   ☐ A lawsuit ☐ A Worker's Compensation claim
   ☐ Neither a lawsuit or Worker's Compensation claim

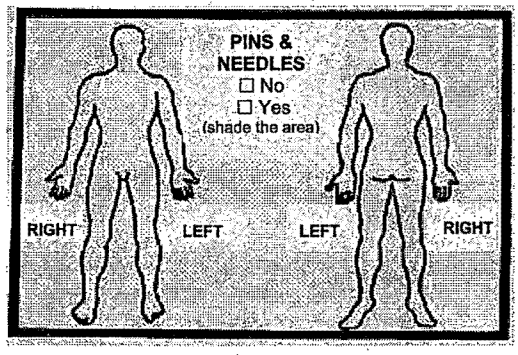
MY PAIN / DISCOMFORT IS (circle number)

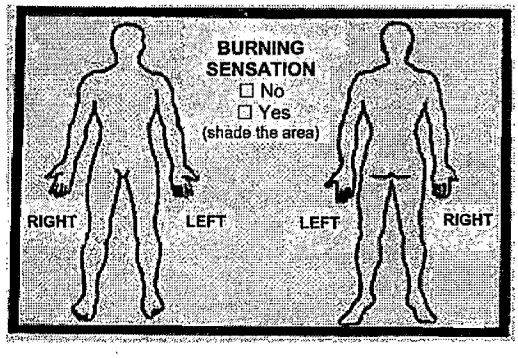
0 1 2 3 4 5 6 7 8 9 10

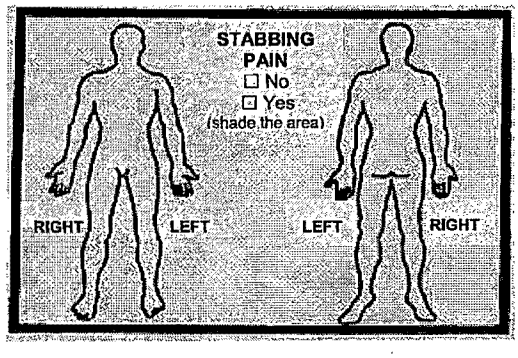
No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be











_____ _____

Patient Signature Date

CURRENT SYMPTOMS

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

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

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

Fill in **one** circle 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?	O	O	O	O	O	O
3. Arm pain?	O	O	O	O	O	O
4. Numbness or tingling in arm and/or hand?	O	O	O	O	O	O
5. Weakness in arm and/or hand?	O	O	O	O	O	O
6. Low back and/or buttocks pain?	O	O	O	O	O	O
7. Leg pain?	O	O	O	O	O	O
8. Numbness or tingling in leg and/or foot?	O	O	O	O	O	O
9. Weakness in leg and/or foot?	O	O	O	O	O	O

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

Fill in **one** circle 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?	O	O	O	O	O	O
11. Arm pain?	O	O	O	O	O	O
12. Numbness or tingling in arm and/or hand?	O	O	O	O	O	O
13. Weakness in arm and/or hand?	O	O	O	O	O	O
14. Low back and/or buttocks pain?	O	O	O	O	O	O
15. Leg pain?	O	O	O	O	O	O
16. Numbness or tingling in leg and/or foot?	O	O	O	O	O	O
17. Weakness in leg and/or foot?	O	O	O	O	O	O

18. Generally speaking, are your symptoms getting better or worse? (Fill in **one** circle)

O Getting much better O Getting somewhat better O Staying about the same

O Getting somewhat worse O Getting much worse

Patients Signature _____ Date _____

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.	O	O	O	O	O
2. ...moderate pain relief.	O	O	O	O	O
3. ...to be able to do more everyday household or yard activities.	O	O	O	O	O
4. ...to sleep more comfortably.	O	O	O	O	O
5. ...to be able to go back to my usual job.	O	O	O	O	O
6. ...to be able to do more sports, to biking, or go for long walks.	O	O	O	O	O

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

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

O Extremely dissatisfied O Very Dissatisfied O Neutral
O Somewhat Satisfied O Very Satisfied O Extremely Satisfied

Patients Signature _____ Date _____

HEALTH STATUS QUESTIONNAIRE (SF-36) Page 1 of 2

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)
   O Excellent O Very Good O Good O Fair O Poor

2. **Compared to <u>one year ago</u>,** how would you rate your health in general **now**? (mark only one)
   O Much better than 1 year ago O Somewhat better than 1 year ago O About the same as 1 year ago O Somewhat worse than 1 year ago O 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.	O	O	O
4. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling or golf.	O	O	O
5. Lifting or carrying groceries.	O	O	O
6. Climbing **several** flights of stairs.	O	O	O
7. Climbing **one** flight of stairs.	O	O	O
8. Bending, kneeling, or stooping.	O	O	O
9. Walking **more than a mile.**	O	O	O
10. Walking **several blocks.**	O	O	O
11. Walking **one block.**	O	O	O
12. Bathing or dressing yourself	O	O	O

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

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

Patients Signature _____ Date _____

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)
    O Not at all O Slightly O Moderately O Quite a bit O Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**? (mark only one)
    O None O Very Mild O Mild O Moderate O Severe O 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)
    O Not at all O A little bit O Moderately O Quite a bit O 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?	O	O	O	O	O	O
24. Have you been a very nervous person?	O	O	O	O	O	O
25. Have you felt so down in the dumps that nothing could cheer you up?	O	O	O	O	O	O
26. Have you felt calm and peaceful?	O	O	O	O	O	O
27. Did you feel full of energy?	O	O	O	O	O	O
28. Have you felt downhearted and blue?	O	O	O	O	O	O
29. Did you feel worn out?	O	O	O	O	O	O
30. Have you been a happy person?	O	O	O	O	O	O
31. Did you feel tired?	O	O	O	O	O	O

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)

    O All of the time O Most of the time O Some of the time O A little of the time O 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.	O	O	O	O	O
34. I am as healthy as anybody I know.	O	O	O	O	O
35. I expect my health to get worse.	O	O	O	O	O
36. My health is excellent.	O	O	O	O	O

Patients Signature _____ Date _____

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.

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 al.

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

Patient Signature_____

Date:____/____/____

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

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	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 **neck** 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**

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	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 **arm** 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**

Patients Signature _____ Date _____

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

_____ _____
Patients Signature Date

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 time

_____ _____
Patients Signature Date

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

_____ _____
Patients Signature Date

_____ _____
Physician Signature Date