

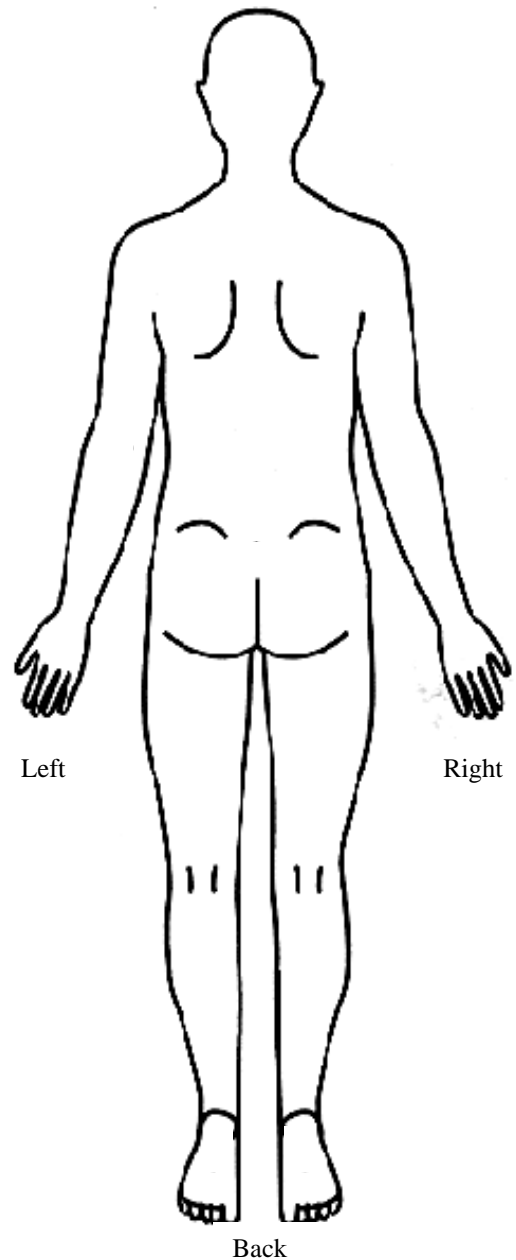
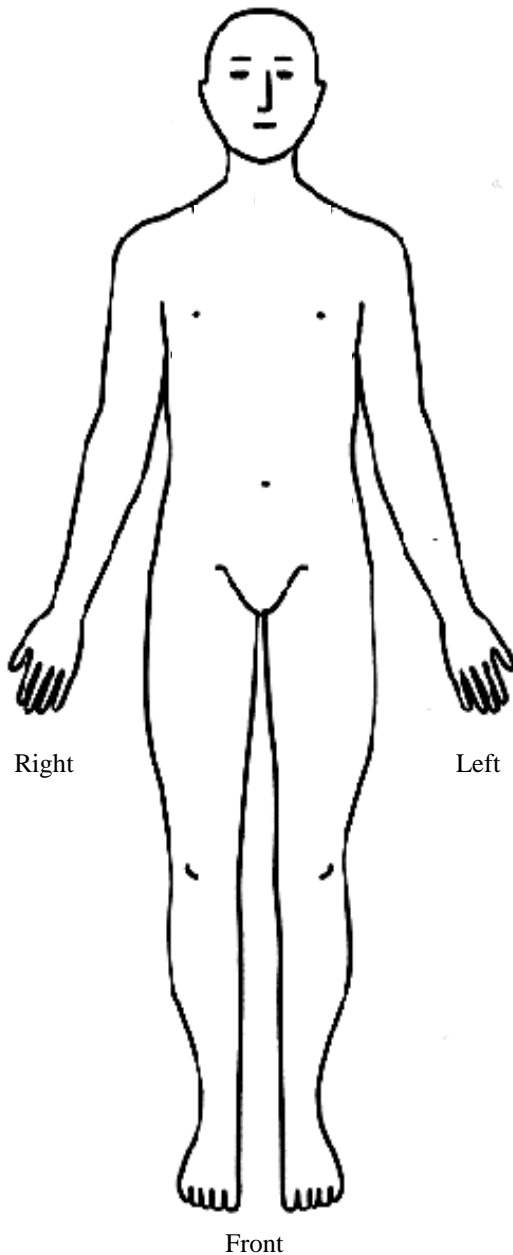
Name: _____

Date: _____

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing. Please diagram your pain using the following symbols:

Numbness: -----	Pins & Needles: oooooooooo
Burning: xxxxxxxxxxxx	Stabbing: //////////////
Other: ***** (Please describe)	



Scoliosis Questionnaire

When did you first notice, or were told you had scoliosis?

Other family members with Scoliosis?

Do you notice any deformity? _____

Is the deformity:

- Getting Better: Staying the same Getting worse

Do you have any back pain? _____

Is the pain:

- Getting Better: Staying the same Getting worse

Do you have any: Leg pain Weakness Numbness

Is this:

- Getting Better: Staying the same Getting worse

How far can you walk? _____

Do you have any bowel or bladder problems? _____

Psychiatric treatment? Now: Yes / No Ever: Yes / No

Who referred you?: _____

Do you want a letter or report sent to the doctor who referred you?: **YES NO**

Dr.'s Address: _____

Dr's Phone number: _____

What do you do for recreation? (every day, weekly, monthly, rarely)

1. _____

2. _____

3. _____

1. Adolescent
2. Congenital
3. Marfan
4. Other: _____
5. Current job: _____

Back surgeries: _____

Dates: _____
X-Ray: _____
MRI: _____
CT: _____
Myelogram: _____

Name: _____

Date: _____

Office use only:

Oswestry: _____

MSPQ: _____

Zung: _____

INSTRUCTIONS: Please fill out the following questionnaire. Mark *only one box per section*. This information will help us understand how your pain affects your daily life.

OSWESTRY**Section 1 – Pain Intensity**

- I can tolerate the pain I have without taking pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain, and I do not use them.

**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 I 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; I 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 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.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than a mile.
- Pain prevents me from walking more than 4 blocks (1/2 mile).
- Pain prevents me from walking more than 2 blocks (1/4 mile).
- I can only walk using a stick or crutches.
- I am in bed most of the day and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair for as long as I like.
- I can only sit in my favorite chair for as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ an hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without any extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from sitting more than ½ an hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

PLEASE CONTINUE ON THE NEXT
PAGE

Section 7 – Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by taking medications.
- Even when I take medication I get less than 6 hours of sleep.
- Even when I take medication I get less than 4 hours of sleep.
- Even when I take medication I get less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex Life

- My sex life is normal and causes me no extra pain.
- My sex life is normal and causes me 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 at all.

Section 9 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases my level of pain.
- Pain has no effect on my social life apart from limiting my more energetic activities (e.g. athletics, dancing, etc.).
- Pain has restricted my social life and I do not go out often.
- Pain has restricted my social life to my home.
- I have no social life because of my pain.

Section 10 -- Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys under 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

Name: _____

Date: _____

Please describe how you have felt during the **PAST WEEK** by making an X in the appropriate box.
Please answer **ALL** questions. Do not think too long before answering.

MSPQ

	Not at all	Slightly A little	A great deal	Extremely Could not have been worse
Heart rate increase...				
Feeling hot all over				
Sweating all over				
Sweating in a particular part of body...				
Pulse in neck...				
Pounding in head...				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal...				
Nausea				
Butterflies in stomach...				
Pain or ache in stomach				
Stomach churning				
Desire to pass water...				
Mouth becoming dry				
Difficulty swallowing...				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles...				

Name: _____

Date: _____

Please indicate (by making an X in the appropriate box) the answer that best describes how you have been feeling recently. Please answer **ALL** questions. Do not think too long before answering.

ZUNG

	Rarely or none of the time	Some of the time (1-2 days per week)	Good part of the time (3-4 days per week)	Most of the time (5-7 days per week)
I feel downhearted and sad				
Morning is when I feel the best...				
I have crying spells, or feel like it				
I have trouble sleeping at night				
I feel that nobody cares				
I eat as much as I used to...				
I still enjoy sex...				
I notice that I am losing weight				
I have troubles with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be...				
I tend to wake up too early				
I find it easy to do the things I used to...				
I am restless and can't keep still				
I feel hopeful about the future...				
I am more irritable than usual				
I find it easy to make decisions...				
I feel quite guilty				
I feel that I am useful and needed...				
My life is pretty full...				
I feel that others would be better off if I were dead				
I still enjoy the things I used to do...				