

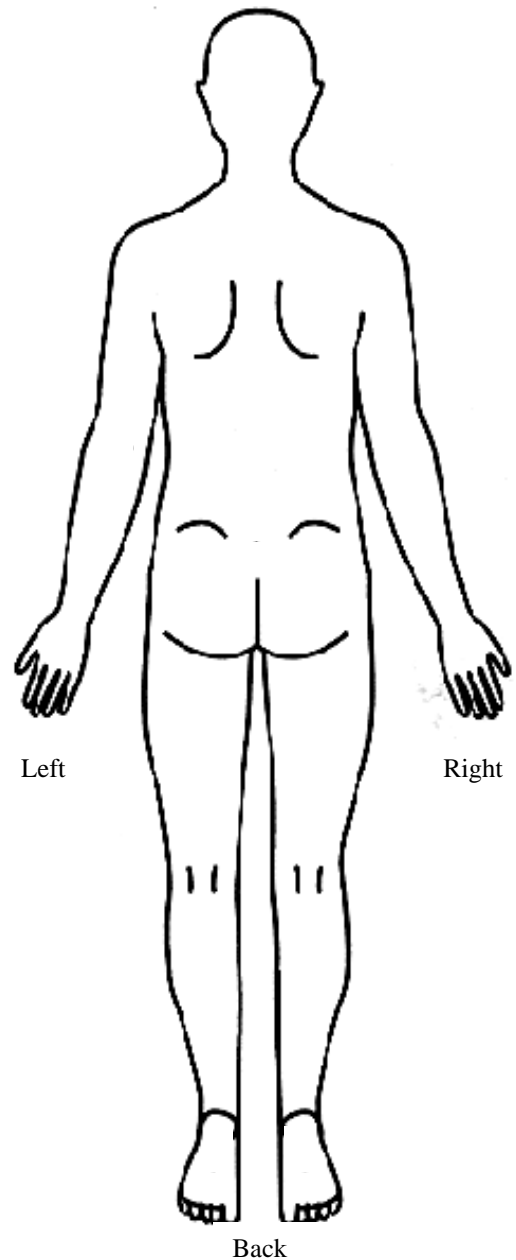
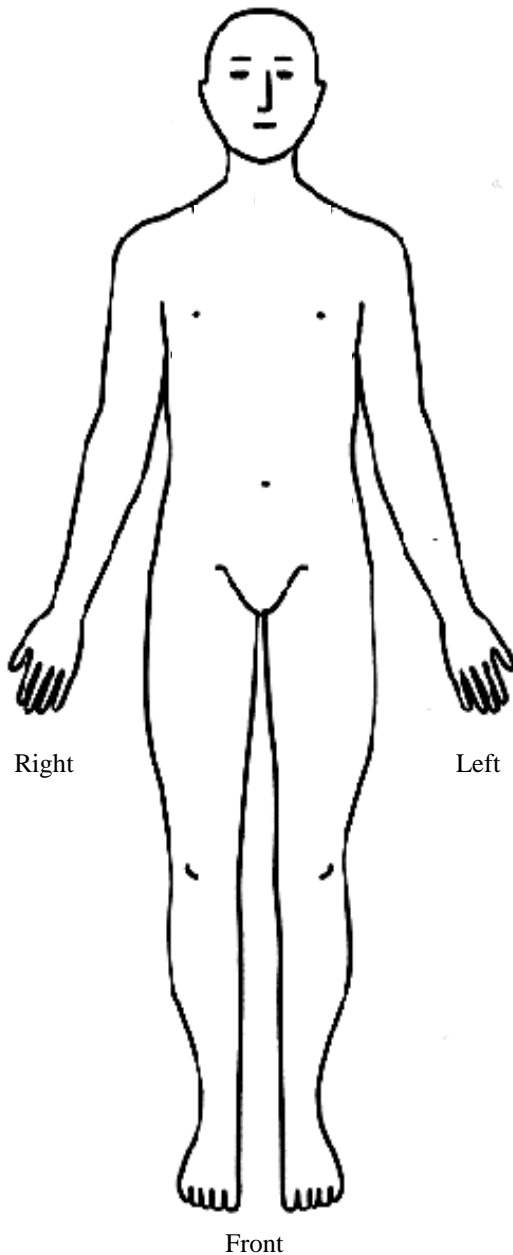
Name: \_\_\_\_\_

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)	



Main Problem: \_\_\_\_\_  
\_\_\_\_\_

Gender:    M    F    Height: \_\_\_\_\_ Weight: \_\_\_\_\_    Years of education completed: \_\_\_\_\_

Date of accident(s): \_\_\_\_\_

Out of work:    Days: \_\_\_\_\_    Months: \_\_\_\_\_    Years: \_\_\_\_\_

Partial days missed work due to your back problems: \_\_\_\_\_

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: \_\_\_\_\_

Recreation (include frequency): \_\_\_\_\_

**PATIENTS WITH BACK, HIP, OR LEG PAIN, ANSWER THE FOLLOWING:**

How long have you had your present attack of back and/or leg pain?: \_\_\_\_\_

When were you first aware there was something wrong with your back?: \_\_\_\_\_

How many attacks of back and/or leg pain have you had per year since then?: \_\_\_\_\_

Rate your present pain on a scale of 0-10

(0 = no pain, 10 = pain so severe you could not live with it more than a few minutes)

Back: \_\_\_\_\_    Right leg: \_\_\_\_\_    Left leg: \_\_\_\_\_    Right hip: \_\_\_\_\_    Left hip: \_\_\_\_\_

Did your back pain get better once the leg pain started? \_\_\_\_\_

Is your back and/or leg pain (*check one*)     Constant:     Intermittent (comes & goes)

Is your back and/or leg pain (*check one*)     Better:     Staying the same     Getting worse

Does your pain in the back and/or leg affect your sleep in any of the following ways? (*check all that apply*)

- Pain does not affect my sleep                       I can't sleep at all because of the pain
- Once I fall asleep I am OK                               I must get up and walk around to relieve the pain
- I awake the same time every night                   I must take medicine to sleep
- I can't sleep on my                       Left side                       Right side                       Stomach

How much time during your usual waking hours do you spend lying down?: \_\_\_\_\_

What makes your pain worse?: \_\_\_\_\_

What makes your pain better?: \_\_\_\_\_

Is the pain worse when first arising?: \_\_\_\_\_

Is the pain worse toward the end of the day?: \_\_\_\_\_

Is the pain worse when first changing position (e.g. standing after sitting)\_\_\_\_\_

Are you experiencing any of the following difficulties? (*check all that apply*)

- Feel like you must urinate, but cannot       Dribbling       Loss of bladder control
- Unable to urinate     Urgent desire to urinate and cannot hold it
- Constipation       Loss of bowel control
- Difficulty with sex

Are you experiencing any of the following difficulties? (*check all that apply*)

- Difficulty walking?      ( Due to pain?)
- Do you stumble?      ( Due to pain?)
- Do you limp?      ( Due to pain?)

Which of your knees “give way”?       Right       Left       Neither

In which foot do you have weakness?       Right       Left       Neither

In which foot do you have numbness?       Right       Left       Neither

Who have you seen for your pain, and when?:

Name(s): \_\_\_\_\_

Type of Doctor/Therapist: \_\_\_\_\_

What treatments have you had for your pain?: \_\_\_\_\_

Which treatments helped your pain the most?: \_\_\_\_\_

How many times have you been hospitalized for your back?: \_\_\_\_\_

Approximate date(s): \_\_\_\_\_

Please list the dates and types of all back surgeries you have had: \_\_\_\_\_

\_\_\_\_\_

Other tests for your back? (number and dates)

CT Scan: \_\_\_\_\_ Myelogram: \_\_\_\_\_

MRI: \_\_\_\_\_ Bone Scan: \_\_\_\_\_

Others (e.g. EMG, SSEP, Epidural Venogram) \_\_\_\_\_

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...				