

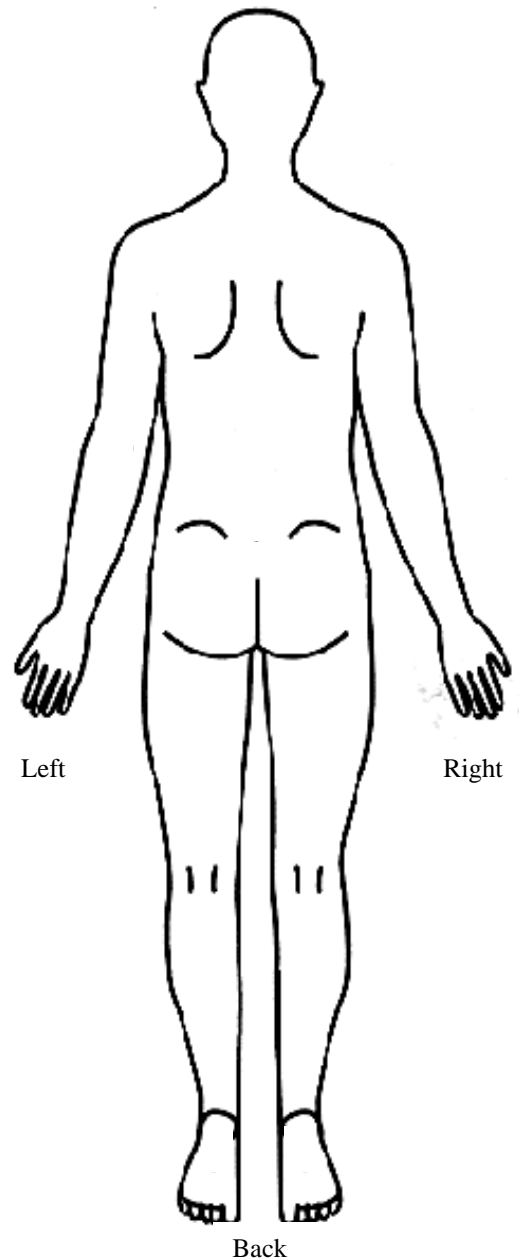
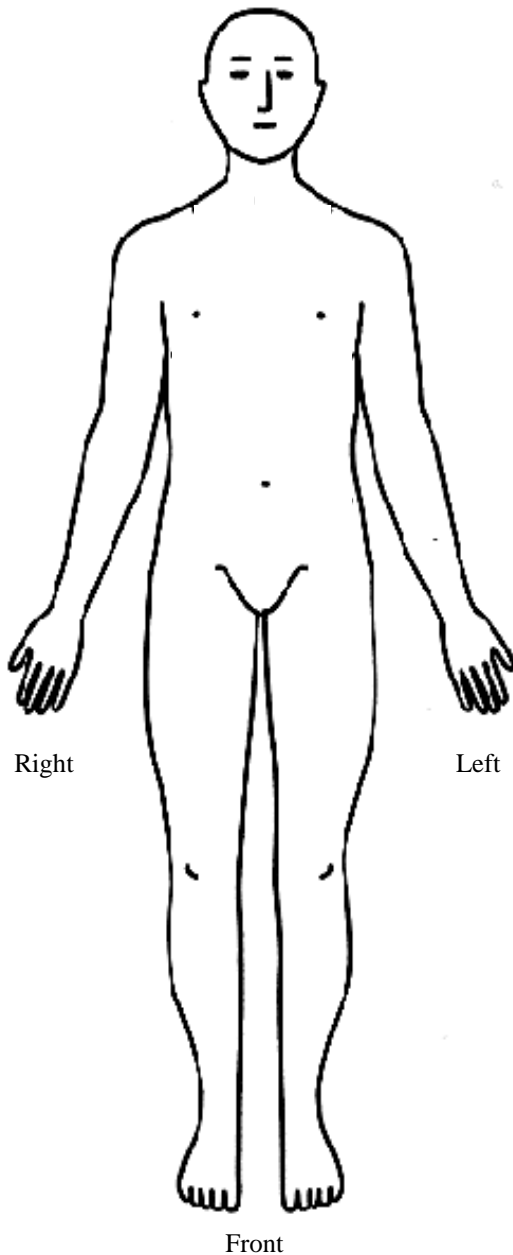
Name: \_\_\_\_\_

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: *****<br>(Please describe) |                            |



### Cervical Spine Questionnaire

How long have you had neck trouble?

What started it? \_\_\_\_\_  
\_\_\_\_\_

TODAY: Rate your pain on a scale of 0-10

(10 is so severe it could only be tolerated for seconds)

|                      |                     |
|----------------------|---------------------|
| _____ Neck           | _____ Headaches     |
| _____ Right Shoulder | _____ Left Shoulder |
| _____ Right Arm      | _____ Left Arm      |

Does your pain interfere with your sleep? Yes / No

Weakness in: \_\_\_ arms? \_\_\_ hands? \_\_\_ legs?

Clumsiness in: \_\_\_ arms? \_\_\_ hands? \_\_\_ legs?

Numbness in hands? Yes / No

Difficulty walking? Yes / No      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. Accident: \_\_\_\_\_

2. Lawsuit: \_\_\_\_\_

3. Worker's Comp: \_\_\_\_\_  
- last day worked: \_\_\_\_\_

4. Current job: \_\_\_\_\_

5. Other occupational injury history:  
\_\_\_\_\_

Neck/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<br>A little | A great deal | Extremely<br>Could not<br>have been<br>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<br>or<br>none of the<br>time | Some of<br>the time<br>(1-2 days<br>per week) | Good part of<br>the time<br>(3-4 days<br>per week) | Most of<br>the time<br>(5-7 days<br>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<br>if I were dead |                                     |   |  |   |
| I still enjoy the things I used to do...                 |                                     |   |  |   |