



Name: _____

Date: _____

The following are some questions given to all pain management patients who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 6. How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |
| 7. How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 9. How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have others expressed concern over your use of medication? | 0 | 1 | 2 | 3 | 4 |
| 11. How often have you felt a craving for medication? | 0 | 1 | 2 | 3 | 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

Please include any additional information you wish about the above answers. Thank you.



ORT PATIENT FORM

Mark each box that applies:

1. Family History of Substance Abuse:

Female Male

Alcohol	<input type="checkbox"/> (1)	<input type="checkbox"/> (3)
Illegal Drugs	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
Prescription Drugs	<input type="checkbox"/> (4)	<input type="checkbox"/> (4)

2. Personal History of Substance Abuse:

Alcohol	<input type="checkbox"/> (3)	<input type="checkbox"/> (3)
Illegal Drugs	<input type="checkbox"/> (4)	<input type="checkbox"/> (4)
Prescription Drugs	<input type="checkbox"/> (5)	<input type="checkbox"/> (5)

3. Age (mark box if between 16-45)

<input type="checkbox"/> (1)	<input type="checkbox"/> (1)
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4. History of Preadolescent Sexual Abuse

<input type="checkbox"/> (3)	<input type="checkbox"/> (0)
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5. Psychological Disease:

Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	<input type="checkbox"/> (2)	<input type="checkbox"/> (2)
Depression	<input type="checkbox"/> (1)	<input type="checkbox"/> (1)

Total:	()	()
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8250 Kenwood Crossing Way, Ste. 101 · Cincinnati, OH 45236 · (513) 221-1917 · FAX (513) 587-3462

We are pleased that you have chosen the Freiberg Spine Institute. We welcome you, and thank you for allowing us to provide for you the best in medical care for your neck and back.

Enclosed is a brochure entitled "In the Forefront of Back Care". This brochure will introduce you to the Spine Institute and share with you our goals in the treatment of spinal disorders. In this brochure is also an information sheet about your doctor, along with a map to help you locate the Institute.

Because of our intensive approach to treatment, it will be necessary for you to fill out an extensive questionnaire dealing with your personal history. This will include questions about your current medical condition, your life-style, your previous care from other medical providers, and your family medical history. This information plays a vital part in your physician's ability to fit a specific treatment to your condition. Please be sure to answer the questionnaire in its entirety.

You will also be required to fill out a registration sheet, giving us the information so that we may bill your insurance carrier.

As this normally takes from 30 to 45 minutes, we are enclosing these forms so that you may complete them at home. Please bring them with you the day of your appointment. If you are unable to complete these forms ahead of time, we request that you call our office so that we may assist you prior to your appointment.

If you have any questions, please feel free to contact us at 221-1917.

INITIAL VISIT QUESTIONNAIRE

Name: _____ Birth Date _____ Today's Date _____

Height: _____ ft. _____ in. Weight: _____ lbs. (Circle one): a. right-handed c. ambidextrous
b. left-handed

1. Who referred you here?
a. primary care doctor c. advertisement e. friend
b. other doctor d. emergency room f. other _____

What was their name, publication, or which ER? _____

2. Have you, or anyone in your family, been seen either here or at the Freiberg Orthopaedic Group? a. yes b. no
If yes, name the family member(s) _____

3. Which doctors are currently treating you for any condition(s)? (circle all that apply and write in their name)
a. family doctor _____ e. cardiologist _____
b. orthopaedist _____ f. others (what type?) _____
c. neurosurgeon _____
d. gynecologist _____ g. NONE

4. Which healthcare providers have you used for your current spine condition? (circle all that apply)
a. acupuncturist c. immediate care clinic i. osteopath m. rheumatologist
b. chiropractor f. internist j. orthopaedic surgeon n. work hardening clinic
c. emergency room g. massage therapist k. pain clinic o. other _____
d. general practitioner h. neurosurgeon l. physical therapist p. NONE

5. Why did you come in today? _____

6. What hurts the most? (circle only one)
a. neck c. arm e. mid back g. buttock i. thigh k. ankle
b. shoulder d. upper back f. low back h. groin j. calf l. foot

7. Was there an injury?
a. car accident c. fall e. NONE
b. work injury d. other _____

8. What was the date of injury OR onset of the problem? _____

9. How long ago did your current episode begin?
a. less than two weeks ago d. three months to less than six months ago
b. two weeks to less than eight weeks ago e. six to twelve months ago
c. eight weeks to less than three months ago f. more than twelve months ago

10. How did your current episode begin?
 a. suddenly
 b. gradually
11. Have you had neck or back symptoms before your current episode?
 a. no
 b. yes, one episode
 c. yes, two or more episodes
12. How many previous neck or back surgeries have you had? _____
13. After your most recent surgery, did you return to work?
 a. no
 b. yes, with limitations
 c. yes, with no limitations
 d. never stopped work
 e. did not work outside the home, currently working as a homemaker
 f. currently a student
 g. retired
 h. did not work, other _____
14. After your most recent surgery, did you return to full function? a. yes b. no
15. When did you very first see a doctor for this problem? _____
16. Were you admitted to a hospital? a. yes b. no
 (If yes, write the name of the hospital) _____
17. What treatments have you had in the past for your back/neck?
 a. pain medicine i. brace q. exercise by therapist
 b. anti-inflammatory j. cane r. manipulation by chiropractor
 c. muscle relaxant k. walker s. massage therapy
 d. oral steroids l. crutches t. back school
 e. local injections m. epidural steroid injection u. neck school
 f. ice packs n. TENS unit v. home exercise program
 g. heating pad or pack o. electrical stimulator w. other _____
 h. traction p. ultrasound x. NONE
18. What current treatment have you received within the last two weeks?
 a. pain medicine i. brace q. exercise by therapist
 b. anti-inflammatory j. cane r. manipulation by chiropractor
 c. muscle relaxer k. walker s. massage therapy
 d. oral steroids l. crutches t. back school
 e. local injection m. epidural steroid injection u. neck school
 f. ice packs n. TENS unit v. home exercise program
 g. heating pad or pack o. electrical stimulator w. other _____
 h. traction p. ultrasound x. NONE

19. Where does the pain start? **(circle only one)**
- | | | | |
|--------------|---------------|------------|----------|
| a. neck | d. upper back | g. buttock | j. calf |
| b. shoulders | e. mid back | h. groin | k. ankle |
| c. arm | f. low back | i. thigh | l. foot |
20. Where does the pain go? **(circle only one)**
- | | | | | |
|--------------|---------------|------------|----------|--------------------|
| a. neck | d. upper back | g. buttock | j. calf | [m. distribution] |
| b. shoulders | e. mid back | h. groin | k. ankle | [] |
| c. arm | f. low back | i. thigh | l. foot | (Dr.'s response) |
21. For questions 19 & 20, is the pain mostly: a. right b. left c. both sides? **(circle one)**
22. What makes the pain worse?
- | | | | |
|-------------|--------------|-------------------------|---------------------------|
| a. standing | g. driving | m. straining | s. going up/down stairs |
| b. walking | h. coughing | n. carrying groceries | t. putting shoes/socks on |
| c. lifting | i. sneezing | o. yard work | u. job |
| d. bending | j. cooking | p. reaching overhead | v. unknown |
| e. twisting | k. vacuuming | q. getting up in a.m. | w. other _____ |
| f. sitting | l. laundry | r. getting in/out chair | x. NOTHING |
23. What makes the pain better?
- | | | |
|-------------------------------|------------------------------------|----------------|
| a. pain medicine | g. lying on side in fetal position | m. exercise |
| b. anti-inflammatories | h. massage | n. walking |
| c. muscle relaxants | i. ultrasound | o. cane |
| d. oral steroids | j. TENS unit | p. crutches |
| e. heating pad | k. traction | q. walker |
| f. lying flat with knees bent | l. manipulation | r. other _____ |
| | | s. NOTHING |
24. When are you pain free? _____
25. How many hours are you able to sleep? _____
26. Does the pain wake you up? a. yes b. no
27. Do you have the pain when you first get up? a. yes b. no
28. What activity almost always causes the pain? _____
29. What activity almost always makes the pain better? _____
30. What is the single thing that this pain has interfered with, or stopped you from doing, that you miss the most?

31. Has your back condition caused new problems with controlling your bladder?
- difficulty in beginning stream
 - wetting yourself unexpectedly
 - wetting yourself when you cough or sneeze
 - continuing bladder problem from other known cause
 - No change
32. Has your back condition caused new problems with controlling your bowels?
- difficulty starting bowel movement
 - loss of control of bowels
 - continuing bowel problem from other known cause
 - No change
33. Has your back condition caused you to have difficulties in obtaining or maintaining an erection?
- Yes
 - No
34. My current level of pain in my lower back/upper buttocks is
- (no pain at all) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
35. My current level of pain in my legs is
- (no pain at all) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
36. Which hurts more, your legs or back?
- legs hurt much more
 - legs hurt somewhat more
 - legs and back hurt about the same
 - back hurts somewhat more
 - back hurts much more
37. My current level of pain in my neck is
- (no pain at all) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
38. My current level of pain in my arms is
- (no pain at all) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)
39. Which hurts more, your arms or neck?
- arms hurt much more
 - arms hurt somewhat more
 - arms and neck hurt about the same
 - neck hurts somewhat more
 - neck hurts much more
40. Did you perform any of the following exercises or activities prior to the onset of your current condition?
- walk, bicycle, swim or other aerobic activity at least 20 minutes a session
 - another form of exercising such as weight lifting, stretching, etc.
 - other _____
 - NONE

41. With your condition do you currently perform any of the following exercises?
 a. walk, bicycle, swim or other aerobic activity at least 20 minutes a session
 b. another form of exercising such as weight lifting, stretching, etc.
 c. other _____
 d. NONE
42. Has the pain stopped you from performing household chores? **(circle all that apply)**
 a. yard work c. laundry e. cooking g. other _____ i. I do not normally perform any of these.
 b. vacuuming d. cleaning f. grocery shopping h. NONE
43. What medications are you taking right now?
 a. pain medication list name _____
 b. anti-inflammatory list name _____
 c. steroids list name _____
 d. muscle relaxants list name _____
 e. high blood pressure list name _____
 f. diabetes medicine list name _____
 g. heart medicine list name _____
 h. asthma medicine list name _____
 i. thyroid medicine list name _____
 j. eye medicine list name _____
 k. hormone replacement list name _____
 l. calcium list name _____
 m. other _____ list name _____
 n. NONE
44. Do you have any of the following allergies?
 a. medications _____

 b. dusts, molds
 c. food (specify) _____
 d. shellfish
 e. iodine
 f. contrast media
 g. other (specify) _____
 h. NONE
45. What reactions do you have?

46. Have you had any of these conditions in the past?
 a. heart attack h. kidney stones
 b. high blood pressure i. gallbladder
 c. asthma / emphysema j. diabetes
 d. blood clots, legs k. seizures
 e. blood clots, lungs l. stroke
 f. ulcers m. alcohol dependence
 g. glaucoma n. chemical dependence
 o. chronic pain (back)
 p. depression
 q. psychiatric condition - if yes, what? _____

 r. cancer - if yes, where? _____
 s. other _____
 t. NONE

47. Have you had any surgeries in the past? If so, when? (Please write the date)
- | | | |
|----------------|--------------------------------------|-----------------------|
| a. back _____ | f. heart _____ | k. gall bladder _____ |
| b. neck _____ | g. abdominal surgery _____ | l. appendectomy _____ |
| c. head _____ | h. uterus (hysterectomy) _____ | m. other _____ |
| d. eyes _____ | i. prostate _____ | n. NONE |
| e. chest _____ | j. cancer (what kind and date) _____ | |

48. Do you have any of the following symptoms now or within the last month?
- | | | |
|-------------------|--------------------------------|---|
| a. headaches | k. night sweats | u. sputum production |
| b. blurred vision | l. night pain | v. pneumonia |
| c. hearing loss | m. diarrhea | w. pain with urination |
| d. tremors | n. constipation | x. get up at night to urinate?
how many times? _____ |
| e. paralysis | o. vomiting | y. weight loss
how much? _____ |
| f. depression | p. blood in stool | z. weight gain
how much? _____ |
| g. pain in chest | q. shortness of breath walking | aa. other _____ |
| h. palpitations | r. leg pain with walking | bb. NONE |
| i. fever | s. shortness of breath at rest | |
| j. chills | t. cough | |

49. This question refers to your **family's** health

Member	Living	Age (now or at death)	How Many	a. cancer (type)	b. diabetes	c. stroke	d. heart disease	e. other (list)
a. mother	yes no							
b. father	yes no							
c. brothers								
d. sisters								
e. sons								
f. daughters								
g. grandchildren								

50. How many years have you, or did you smoke?
- | | | |
|----------------------|-----------------------|---------|
| a. less than 5 years | c. 11-20 years | e. NONE |
| b. 6-10 years | d. more than 20 years | |
51. If you quit smoking, how long ago did you quit?
- | | |
|----------------------|-----------------------|
| a. less than 5 years | c. 11-20 years |
| b. 6-10 years | d. more than 20 years |
52. How much do you **currently** smoke?
- | | | |
|-------------------------|--------------------------------|---------|
| a. 10-20 cigarettes/day | c. more than 40 cigarettes/day | e. NONE |
| b. 20-40 cigarettes/day | d. other | |

53. How much alcohol do you drink?
 a. holidays only d. 1-2 drinks a day g. NONE
 b. social events e. 3-4 drinks a day
 c. weekends f. more than 4 drinks a day
54. Do you follow any special diets? a. yes b. no
 (if yes, what is your diet)?
-
55. What is your combined annual family income?
 a. \$0 - \$20,000 c. \$40,001 - \$60,000
 b. \$20,001 - \$40,000 d. Above \$60,000
56. What is your current marital status?
 a. married/living with a significant other c. widowed
 b. divorced/separated d. single
57. What do you live in?
 a. apartment/condo b. ranch house c. multi-level house d. mobile home
58. How many **flights** of stairs are present? _____
59. Who lives with you in your home? **(circle all that apply)**
 a. spouse c. sibling(s) e. parent g. no one else
 b. children d. significant other f. others
60. How much schooling have you completed?
 a. completed less than high school d. graduated from a 2 year associate degree program or technical school
 b. graduated from high school e. graduated from college (Bachelors degree or equivalent)
 c. completed 1 to 3 years of college f. completed post-graduate or professional degree
61. How many jobs have you had in the last 3 years?
 a. one or two b. three or more c. NONE
62. Are you self-employed? a. yes b. no
63. What is your primary occupation? If you are not working now, what was your primary occupation and employer?
 (please be as specific as possible)
 Occupation _____
 Employer _____
64. Which statement describes your current employment situation? **(circle all that apply)**
 a. currently working d. unemployed g. retired (not due to health)
 b. on paid leave e. homemaker h. disabled and/or retired because of back problems
 c. on unpaid leave f. student i. other, please specify _____

77. How do you get paid?
 a. hourly c. salary e. commission only
 b. hourly plus commission d. salary plus commission f. other
78. Other than your salary, what other sources of income does your household receive? **(circle all that apply)**
 a. another person's salary d. disability
 b. state support e. other (investments, retirement plan, etc.)
 c. social security f. no other source of income
79. Are you experiencing financial difficulties because of your back condition?
 a. only a little c. a lot
 b. some d. NONE at all

Are you planning to apply for any of the following programs?

		no	already on it	applied for it	planning to apply for it
80.	Social Security	0	1	2	3
81.	Disability	0	1	2	3
82.	Workers Compensation	0	1	2	3

83. Do you think the fault for your current back condition is: **(circle all that apply)**
 a. yours c. a co-worker's e. no one's
 b. your employer's d. another person's
84. Have you hired a lawyer because of your back condition?
 a. yes, I have and the case has **NOT** been settled
 b. yes, I have and the case has been settled
 c. no, I have not hired a lawyer

As a result of my treatment, I expect:

		Not likely	Slightly likely	Somewhat likely	Very likely	Extremely likely
85.	Complete pain relief	1	2	3	4	5
86.	Moderate pain relief	1	2	3	4	5
87.	To be able to do more everyday household or yard activities	1	2	3	4	5
88.	To be able to sleep more comfortably	1	2	3	4	5
89.	To be able to go back to my usual job	1	2	3	4	5
90.	To be able to do more sports, go biking, or go for long walks	1	2	3	4	5

91. What other results do you expect from your treatment? Please describe.

How important is:

		Not important	Slightly important	Somewhat important	Very important	Extremely important
92.	Complete pain relief	1	2	3	4	5
93.	Moderate pain relief	1	2	3	4	5
94.	To be able to do more everyday household or yard activities	1	2	3	4	5
95.	To be able to sleep more comfortably	1	2	3	4	5
96.	To be able to go back to my usual job	1	2	3	4	5
97.	To be able to do more sports, go biking, or go for long walks	1	2	3	4	5
98.	Other (refer to your answer to #91 above)	1	2	3	4	5

PATIENT ACTIVITY

Questions 99 - 106:

Back and leg pain patients answer NON-SHADED sections only.
Neck and arm pain patients answer SHADED sections only.

In the **past week**, how often have you suffered from the following?

		None	A Little	Some	A good bit	Most of the time	All the time
99.	Low back and/or buttock pain	1	2	3	4	5	6
	Neck and/or shoulder pain	1	2	3	4	5	6
100.	Leg pain	1	2	3	4	5	6
	Arm pain	1	2	3	4	5	6
101.	Numbness or tingling in leg and/or foot	1	2	3	4	5	6
	Weakness in leg and/or foot (such as difficulty lifting foot)	1	2	3	4	5	6
102.	Weakness in leg and/or foot (such as difficulty lifting foot)	1	2	3	4	5	6
	Weakness in arm and/or hand (such as difficulty holding object)	1	2	3	4	5	6

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

		None	Slightly	Somewhat	Moderately	Very	Extremely
103.	Low back and/or buttock pain	1	2	3	4	5	6
	Neck and/or shoulder pain	1	2	3	4	5	6
104.	Leg pain	1	2	3	4	5	6
	Arm pain	1	2	3	4	5	6
105.	Numbness or tingling in leg and/or foot	1	2	3	4	5	6
	Numbness or tingling in neck and/or arm	1	2	3	4	5	6
106.	Weakness in leg and/or foot (such as difficulty lifting foot)	1	2	3	4	5	6
	Weakness in arm and/or hand (such as difficulty holding object)	1	2	3	4	5	6

Note: From this point on, **all patients** (Back and Neck) continue to **answer all** of the following questions.

How much of the time **during the last week:**

		All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
107.	Have you been very nervous?	1	2	3	4	5	6
108.	Have you felt so down in the dumps nothing could cheer you up?	1	2	3	4	5	6
109.	Have you felt calm and peaceful?	1	2	3	4	5	6
110.	Have you felt downhearted and blue?	1	2	3	4	5	6
111.	Have you been a happy person	1	2	3	4	5	6

How often do you need to use the following assistive devices?

		Never	Sometimes	About 1/2 the time	Often	All the time
112.	1 or 2 canes	1	2	3	4	5
113.	1 or 2 crutches	1	2	3	4	5
114.	walker	1	2	3	4	5
115.	wheelchair	1	2	3	4	5

116. Getting dressed (in the last week)

- | | |
|---|---|
| a. I can dress myself without pain | d. I can dress myself but with significant pain |
| b. I can dress myself without increasing pain | e. I can dress myself but with very severe pain |
| c. I can dress myself but pain increases | f. I can not dress myself |

117. Lifting (in the last week)

- I can lift heavy objects without pain
- I can lift heavy objects but it is painful
- pain prevents me from lifting heavy objects off the floor but I can manage
- pain prevents me from lifting heavy objects but I can manage light to medium objects if they are on the table
- I can lift only light objects
- I can not lift anything

118. Walking (in the last week)

- | | |
|---|---|
| a. pain does not prevent me from walking | e. I can only walk a few steps at a time. |
| b. pain prevents me from walking more than 1 hour | f. I am unable to walk. |
| c. pain prevents me from walking more than 30 minutes | |
| d. pain prevents me from walking more than 10 minutes | |

119. Sitting (in the last week)
- a. I can sit in any chair as long as I like
 - b. I can only sit in a special chair for as long as I like
 - c. pain prevents me from sitting more than 1 hour
 - d. pain prevents me from sitting for more than 30 minutes
 - e. pain prevents me from sitting for more than a few minutes
 - f. I am unable to sit
120. Standing (in the last week)
- a. I can stand as long as I like
 - b. I can stand as long as I like but it gives me pain
 - c. pain prevents me from standing for more than 1 hour
 - d. pain prevents me from standing for more than 30 minutes
 - e. pain prevents me from standing for more than a few minutes
 - f. pain prevents me from standing at all
121. Sleeping (in the last week)
- a. I sleep well
 - b. pain occasionally interrupts my sleep
 - c. pain interrupts my sleep half of the time
 - d. pain often interrupts my sleep
 - e. pain always interrupts my sleep
 - f. I never sleep well
122. Social and recreational life (in the last week)
- a. my social and recreational life is unchanged
 - b. my social and recreational life is unchanged but it increases pain
 - c. my social and recreational life is unchanged but it severely increases pain
 - d. pain has restricted my social and recreational life
 - e. pain has severely restricted my social and recreational life
 - f. I have essentially no social and recreational life because of pain
123. Traveling (especially in a car) (in the last week)
- a. I can travel anywhere
 - b. I can travel anywhere but it gives me pain
 - c. pain is bad but I can manage to travel over 2 hours
 - d. pain restricts me to trips of less than 1 hour
 - e. pain restricts me to trips of less than 30 minutes
 - f. pain prevents me from traveling
124. Sex life (in the last week)
- a. my sex life is unchanged
 - b. my sex life is unchanged but causes some extra pain
 - c. my sex life is nearly unchanged but it is painful
 - d. my sex life is severely restricted by pain
 - e. my sex life is nearly absent because of pain
 - f. pain prevents any sex life at all

Thank you for taking the time to complete this questionnaire.

Office Locations:
 Kenwood
 Western Hills
 Mt. Airy



TEL: (513) 221-5500
 FAX: (513) 221-1362
 www.freibergortho.com



NAME: _____ DATE: _____

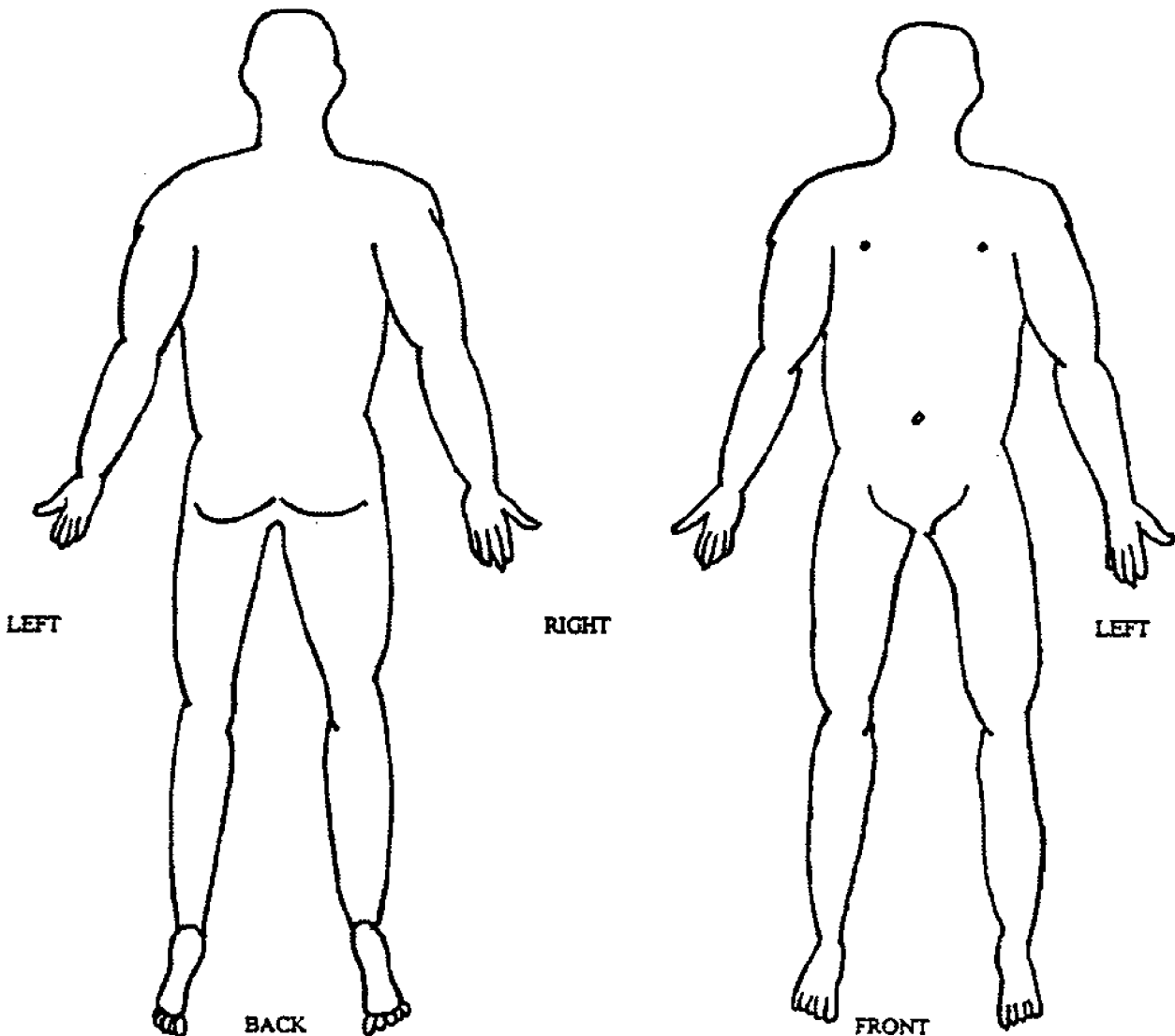
PLEASE GIVE THIS PAPER TO THE DOCTOR AT THE TIME OF EXAMINATION

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation, include all affected areas. Please draw in your face.

	=====		0000		XXXX		////		AAAA
NUMBNESS	=====	PINS & NEEDLES	0000	BURNING	XXXX	STABBING	////	ACHE	AAAA
	=====		0000		XXXX		////		AAAA

BACK

FRONT



**BACK PAIN QUESTIONNAIRE
PATIENT HISTORY**

NAME: _____

AGE: _____

DATE: _____

How long have you had the present pain?

How long have you had *any* trouble with your back, legs, or neck?

How long have you been off work or unable to do normal housework?

Did your pain begin: GRADUALLY SUDDENLY FROM AN INJURY AT WORK

Is your pain: CONTINUOUS OFF & ON NEITHER

My pain is: (check appropriate box)	BETTER	WORSE	UNCHANGED
WITH COUGH OR SNEEZE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SITTING DOWN AT A TABLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SITTING IN AN AUTOMOBILE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BENDING FORWARD TO BRUSH TEETH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING SHORT DISTANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYING FLAT ON BACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYING FLAT ON STOMACH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYING ON SIDE WITH KNEES BENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MID-MORNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MIDDLE OF THE NIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My back sometimes gets " <i>stuck</i> " when I bend forward	YES	NO
My back feels it is likely to give way when I bend forward	YES	NO
My pain stops me after I walk a certain distance	YES	NO
After walking, bending forward improves my pain	YES	NO

How many times have you been in a hospital for back, leg, or neck problems?

Have you had previous back surgeries? YES NO TYPE? _____

Have you had other types of surgeries? YES NO TYPE? _____

Have any treatments made your pain better? YES NO WHAT TREATMENTS? _____

Have any treatments made your pain worse? YES NO WHAT TREATMENTS? _____

What is the most aggravation thing about your pain?

OCCUPATION: _____