Patient Questionnaire - Lower Quarter and Lumbar Spine

Date: _____

(Please be thorough and fill out all that is applicable)

Patient (print): _____ **Date of Birth:** _____ **Age:** _____

Date of Injury or Onset of Symptoms: _____ **Return to Doctor Appointment:** _____

Date of Surgery: _____ **Type of Surgery:** _____

Please provide a brief history of your present condition and how did this begin: _____

_____

Your primary concern/chief complaint about your *CURRENT* condition: _____

_____

***CURRENT* Limitations of Function — Check *ALL* areas you *ARE CURRENTLY LIMITED*:**

- ❑ Self Care: Cooking, Shopping, Cleaning
- ❑ Mobility: Walking & Moving Around
- ❑ Changing & Maintaining Body Position
- ❑ Carrying, Moving & Handling Objects

CURRENT* Level of Function —** (% of your ***normal ability): ❑ 0% (unable to care for self) ❑ 10% ❑ 25% ❑ 50% ❑ 75% ❑ 100% ❑ Other: ___%

Pain Location: (*be specific*): ❑ Left ❑ Right ❑ Both ❑ Foot/Feet: _____

_____

What is the intensity of your *PRIMARY SOURCE OF PAIN* (i.e., why you are beginning Hand Therapy)?

	0 = None				5 = Moderate					10 = Extreme
Circle your pain at its' ***LOWEST:***	0	1	2	3	4	5	6	7	8	9	10
Circle the pain you have ***RIGHT NOW:***	0	1	2	3	4	5	6	7	8	9	10
Circle your pain at its' ***HIGHEST:***	0	1	2	3	4	5	6	7	8	9	10

Describe your pain — Check *ALL* areas that apply:

- ❑ Burning ❑ Sharp ❑ Numbness/Tingling ❑ Throbbing ❑ Shooting
- ❑ Dull/Achy ❑ Other(s), Describe: _____
- ❑ If numbness, tingling, and/or shooting ***where does the pain START and END***? _____

_____

What aggravates your pain — Check *ALL* areas that *INCREASE(S)* your pain:

- ❑ Sitting ❑ Standing ❑ Sit-to-Stand ❑ Bending ❑ Walking
- ❑ Going to the Restroom ❑ Coughing/Sneezing ❑ Lying Down ❑ Driving ❑ Lifting/Carrying
- ❑ Other(s), Describe: _____

What can you do to decrease your pain — Check *ALL* areas that *DECREASE(S)* your pain:

- ❑ Sitting ❑ Standing ❑ Walking ❑ When Still ❑ Mornings ❑ Evenings
- ❑ Lying Down ❑ Movement: Describe: _____
- ❑ Other(s), Describe: _____

Name of Occupation: _____ **Out of Work Since:** _____ **Return to Work Date:** _____

Work Status — Check the *ONE* that best describes your status: ❑ Full Time ❑ Part Time
❑ Light Duty ❑ Transitional Duty ❑ Out of Work ❑ Retired ❑ Not Working ❑ Homemaker

Description of your Occupation: ❑ Sedentary ❑ Light ❑ Medium ❑ Heavy ❑ Very Heavy

Is there an attorney involved? ❑ Yes ❑ No **— Who?** _____ **Attorney's Office #:** _____

Medical History — Check *ALL* that apply *AND* provide descriptions:

❑ Osteoarthritis _____

❑ Diabetes Mellitus: _____
If yes: ❑ Type 1 ❑ Type 2
Managed: ❑ Insulin ❑ Meds. ❑ Diet

❑ Currently Pregnant _____

❑ Cancer: _____

❑ Epilepsy/Seizures _____

❑ Migraines/Headaches _____
If yes, is the pain: ❑ Greater on one side
❑ Equal on both sides

❑ Prior Therapy: ❑ OT ❑ PT ❑ Chiropractic
For: _____

❑ Implantable medical device(s)_____
❑ Pacemaker
❑ Defibrillator
❑ Other: _____

❑ Cardiovascular Disease _____

❑ Emotional/Psychological _____

❑ Allergies _____

❑ Asthma _____

❑ Smoking: _____
If yes: Packs per day: _____
Quit? __ year(s) __ month(s) __ week(s) __ day(s)

❑ Dizziness/Fainting: Describe: _____
❑ Trigger(s):_____
❑ How Long Does the Dizziness Last:_____

❑ Surgical History_____

❑ Splint/Cast/Sling: If so, how long? _____
Type: _____

❑ History of Falls: ❑ Yes ❑ No, If Yes, Explain:
_____

Diagnostic Testing/Procedures — Check *ALL* that apply *WITH DATES & RESULTS:*

❑ CT - Date: _____ Results: _____

❑ MRI - Date: _____ Results: _____

❑ EMG - Date: _____ Results: _____

❑ Myelogram - Date: _____ Results:_____

❑ Bone Scan - Date: _____ Results: _____

❑ Other _____ - Date: _____ Results: _____

❑ Steroid Injections in Muscles - Date: _____
Results _____

❑ Epidural Steroid Injections - Date: _____
Results _____

Current Medications — Check *ALL* that apply *AND* provide dosages — Attach a list if necessary

❑ Not Currently Taking Any Medications ❑ Prescription_____

❑ Over The Counter_____ ❑ Herbals_____

❑ Vitamins & Minerals_____ ❑ Dietary & Nutritional Supplements _____

What are your Hobbies? _____

What are your Physical Therapy Goals? _____

Current Weight: _____ **Current Height**: _____

Back Index

ACN Group, Inc. Form BI-100

(Oswestry Disability Index)

PLEASE FILL OUT PRIOR TO YOUR APPOINTMENT

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score