

Spine Patients



NEUROSURGICAL ASSOCIATES, LTD.

Patient Name:

Birth Date:

Gender:

Appt Date:

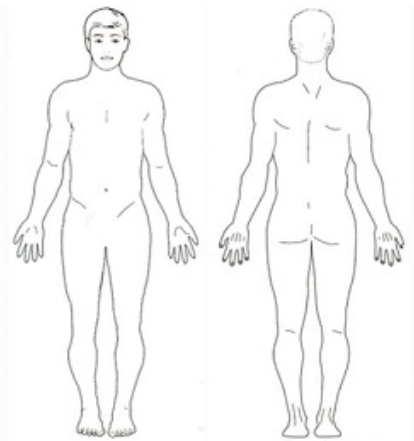
MRN:

Rendering Provider:

Where is your pain now?

Mark with X's where you have symptoms

How would you describe your pain?



- Aching
- Burning
- Stinging
- Tingling
- Stabbing
- Pressure
- Weakness
- Other

What makes your symptoms worse?

What makes your symptoms better?

Have you had trouble controlling your bowel or bladder? Yes No

If yes, is this a new problem? Yes No

How severe is your **back** pain today? Please place an X in a box below to indicate how bad you feel your back pain is today.

No Pain Intolerable

How severe is your **leg** pain today? Please place an X in a box below to indicate how bad you feel your leg pain is today.

No Pain Intolerable

Please continue on other side



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PATIENT LABEL

Oswestry Low Back Pain Disability Questionnaire

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark **one** box only in each section that most closely describes you today.

SECTION 1 - PAIN INTENSITY

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

SECTION 2 -PERSONAL CARE

- I can look after myself normally without causing additional pain
- I can look after myself normally but it is very painful
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of my personal care
- I do not get dressed, I was with difficulty and I stay in bed

SECTION 3 - LIFTING

- I can lift heavy weights without additional pain
- I can lift heavy weights, but it gives me additional 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 but I can manage light to medium if they are conveniently positioned, e.g. on a table
- I can lift only 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 one mile
- Pain prevents me from walking more than a quarter of a mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a cane or crutches
- I am in bed most of the time and have to crawl to the toilet

SECTION 5 -SITTING

- I can sit in any chair as long as I like
- I can sit in my favorite chair as long as I like
- Pain prevents me from sitting for more than 1 hour
- Pain prevents me from sitting for more than half an hour
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all

SECTION 6 - STANDING

- I can stand as long as I want without additional pain
- I can stand as long as I want, but it give me additional pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than half an hour
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Please continue on other side



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SECTION 7 - SLEEPING

- My sleep is never interrupted by pain
- My sleep is occasionally interrupted by pain
- Because of pain I have less than 6 hours of sleep
- Because of pain I have less than 4 hours of sleep
- Because of pain I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

SECTION 8 - SEX LIFE

- My sex life is normal and causes no additional pain
- My sex life is normal but causes some additional pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly non-existent because of pain
- Pain prevents me from having any sex life at all

SECTION 9 - SOCIAL LIFE

- My social life is normal and causes me no additional pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to home
- I have no social life because of pain

SECTION 10 - TRAVELING

- I can travel anywhere without pain
- I can travel anywhere but it gives me additional pain
- Pain is bad but I am able to manage trips over 2 hours
- Pain restricts me to trip of less than one hour
- Pain restricts me to short necessary trips under 30 minutes
- Pain prevents me from traveling except to receive treatment

Global Health Scale - Please respond to each item by marking one box per row

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, would you say your quality of life is:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your mental health, including your mood and your ability to think?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, how would you rate your satisfaction with your social activities and relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please continue on other side



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In the past 7 days....

How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

Never Rarely Sometimes Often Always

How would you rate your fatigue on average?

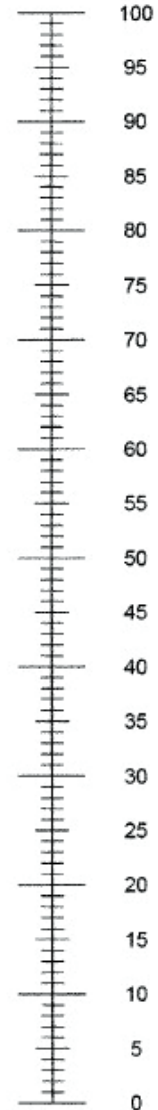
None Mild Moderate Severe Very Severe

How would you rate your pain on average?

No pain Worst imaginable pain

We would like to know how good or bad your health is TODAY

The best health you can imagine



- This scale is numbered from 0 - 100
- 100 means the best health you can imagine
0 means the worst health you can imagine
- Mark an X on the scale to indicate how your health is TODAY
- Now, please write the number you marked on the scale in the box below

YOUR HEALTH TODAY =

Empty rectangular box for recording the health score.

The worst health you can imagine

Thank you for completing our Spine Information form



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