Michigan Orthopedic Center

TELL ME ABOUT YOUR BACK PROBLEMS: ***(please complete <u>both</u> sides!)***

Name_____ _____ Date of birth:_____ Date:_____

E-mail:_____

<u>(Note: R = Right, L = Left)</u>

1. **How would you characterize the onset of your low back pain?**
   - ☐ Sudden
   - ☐ Gradual
   - ☐ Unknown
2. **What has the pattern of your back pain been?**
   - ☐ Increasing
   - ☐ Decreasing
   - ☐ Unchanging
   - ☐ Episodic
3. ***<u>About</u>* how long has your back hurt you?**
   - ____ years
   - ____ months
   - _____ exact date of onset (if known)
4. **Where exactly is your back pain/feeling of stiffness located?**
   - R ☐ L ☐ Groin
   - R ☐ L ☐ Side of low back
   - R ☐ L ☐ Lateral thigh (away from other thigh)
   - R ☐ L ☐ Medial thigh (near other thigh)
   - R ☐ L ☐ Front of thigh
   - R ☐ L ☐ Back of thigh
   - R ☐ L ☐ Buttock
   - R ☐ L ☐ Lower back
   - R ☐ L ☐ Calf
   - R ☐ L ☐ Foot
   - R ☐ Other:_____
   - L ☐ Other:_____
5. **How would you characterize your back problem?**
   - ☐ An inconvenience
   - ☐ More than an inconvenience
   - ☐ Disabling
6. **Rate your average back pain over the last week.**
   - ☐ none=0 1 2 3 4 5 6 7 8 9 10=severe
7. **What best describes your back pain?**
   - ☐ Aching
   - ☐ Sharp
   - ☐ Throbbing
   - ☐ Burning
   - ☐ Tingling
   - ☐ Intermittent
   - ☐ Constant
   - ☐ Numbness
   - ☐ Other:_____
8. **What aggravates your back pain?**
   - ☐ Nothing
   - ☐ Bending
   - ☐ Lying on affected side
   - ☐ Lying on flat surface
   - ☐ Sitting
   - ☐ Lifting
   - ☐ Getting out of a chair
   - ☐ Getting in and out of a car
   - ☐ Riding in a car
   - ☐ Prolonged walking
   - ☐ Running
   - ☐ Prolonged standing
   - ☐ Climbing stairs
   - ☐ Descending stairs
   - ☐ Change in weather patterns
   - ☐ Other:_____
9. **About how far can you walk at one time?**
   - _____ Unlimited
   - _____ Greater than 10 Blocks
   - _____ 5-10 Blocks
   - _____ Less than 5 Blocks
   - _____ Indoors Only
   - _____ Unable to Walk
   - Other: _____
10. **What initially brought on your back pain?**
    - ☐ Not sure
    - ☐ Trauma
    - ☐ Other:_____

11. What relieves or lessens your back pain?

☐ Nothing
☐ Rest
☐ Heat
☐ Ice
☐ Injections
☐ Lying down
☐ Sitting
☐ Walking assist device
☐ Exercise
☐ Standing
☐ Walking
☐ Medication
☐ Chiropractic
☐ Physical Therapy
☐ Topical Ointments (i.e. Bengay)
☐ Other:_____

12. What are the associated features of your back pain?

☐ Keeps me from sleeping at night
☐ Frequently awakens me from sleep
☐ Stiffness
☐ Limping
☐ Catching
☐ Giving way
☐ Decreased range of motion
☐ Difficulty shopping
☐ Difficulty doing housework
☐ Difficulty putting on shoes and socks
☐ Difficulty with sports activities
☐ Difficulty walking a distance
☐ Other:_____

13. What previous diagnostic tests have you had on your back?

☐ None
☐ Plain radiographs
☐ MRI
☐ CT
☐ Bone Scan
☐ EMG
☐ Other:_____

14. Note if any of the following have evaluated or treated your back, hip or lower extremities.

☐ Orthopedic surgeon
☐ Neurosurgeon
☐ Neurologist
☐ Rheumatologist
☐ Chiropractor
☐ Pain management
☐ Other:_____

15. Have you had physical therapy for your back?

Yes ☐ **(if yes, when?)** No ☐

_____
_____

16. Have you had any previous surgeries on your back?

☐ Yes ☐ No

(if yes, list the surgeries for each and when they were done)

_____
_____

17. Which assistive device do you use?

☐ None
☐ Cane
☐ Crutch
☐ Walker
☐ Wheelchair
☐ Shopping basket
☐ Motorized scooter
☐ Other

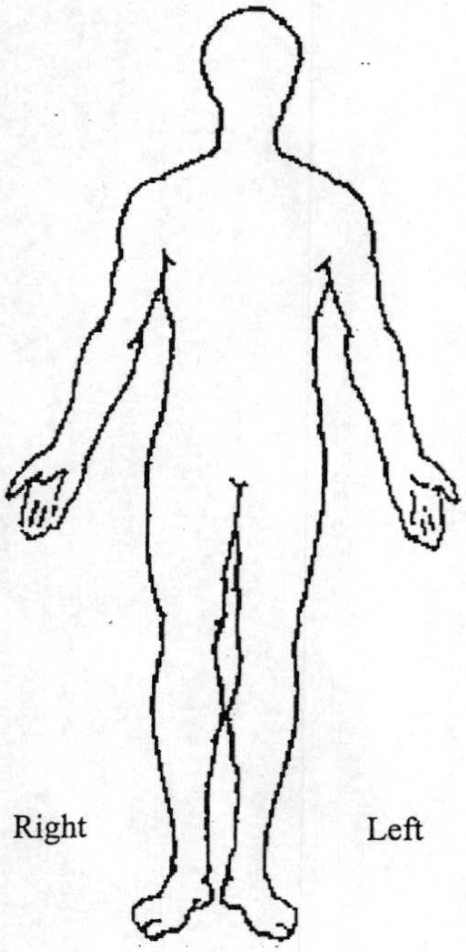
18. What medications have you taken?
(mark a P for those used in PAST)
(mark a C for those used CURRENTLY)

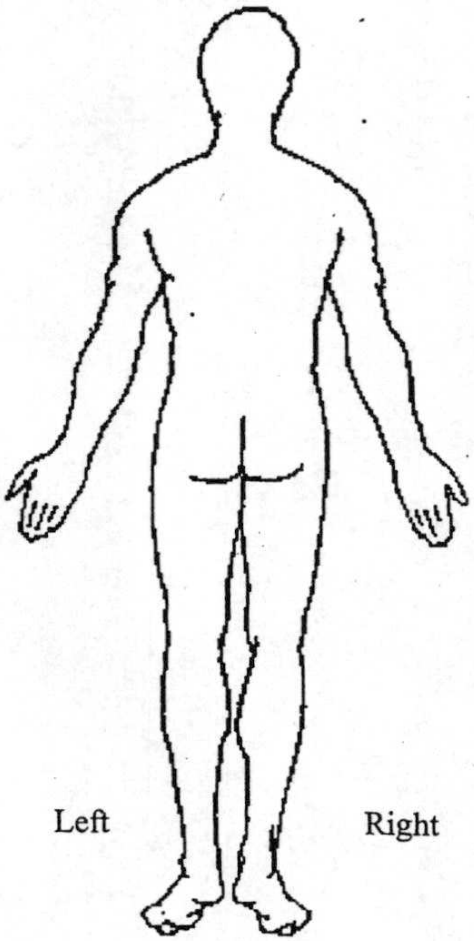
___ None
___ Tylenol
___ Aspirin
___ Topical Rub/Pain Patch
___ NSAID (Ibuprofen/Motrin/Advil, Aleve)
___ Other NSAID: _____
___ Clinoril/Sulindac
___ Celebrex
___ Mobic/Meloxicam
___ Cortisone injection
___ Ultram/Tramadol/Ultracet
___ Narcotic: _____
___ Glucosamine / Chondroitin
___ Other: _____

PATIENT PAIN DRAWING

Where is your pain now?
Using the appropriate symbols below, mark the areas on your body where you feel the sensations described. Mark the areas of radiation. Include all affected areas. To complete the picture please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	===	O O O	X X X	/ / /





How bad is your pain now?
Please mark an X on the body form where the pain is worst now. Please circle on the line below how bad your pain is now.

NO PAIN_____ WORST POSSIBLE PAIN

1 2 3 4 5 6 7 8 9 10

PAIN DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give your physician information as to how your pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the one box that best describes your condition today. Please mark only the box that most closely describes your current condition.

Patient Name: _____ **DOB:**_____

Pain Intensity

- ❑ I can tolerate the pain I have without having to use pain medication.
- ❑ The pain is bad, but I can manage without having to take pain medication.
- ❑ Pain medication provides me with complete relief from pain.
- ❑ Pain medication provides me with moderate relief from pain.
- ❑ Pain medication provides me with little relief from pain.
- ❑ Pain medication has no effect on my pain.

Personal Care (e.g., washing, dressing)

- ❑ I can take care of myself normally, without causing increased pain.
- ❑ I can take care of myself normally, but it increases my pain.
- ❑ It is painful to take care of myself, and I am slow and careful.
- ❑ I need help, but I am able to manage most of my personal care.
- ❑ I need help every day in most aspects of my care.
- ❑ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights, but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Walking

- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than 1 mile. (1 mile = 1/6 km).
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can walk only with crutches or a cane.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can only 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 ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

(OVER)

Standing

- ❑ I can stand as long as I want without increased pain.
- ❑ I can stand as long as I want, but it increases my pain.
- ❑ Pain prevents me from standing for more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Sleeping

- ❑ Pain does not prevent me from sleeping well.
- ❑ I can sleep well only by using pain medication.
- ❑ Even when I take medication, I sleep less than 6 hours.
- ❑ Even when I take medications, I sleep less than 4 hours.
- ❑ Even when I take medications, I sleep less than 2 hours.
- ❑ Pain prevents me from sleeping at all.

Social Life

- ❑ My social life is normal and does not increase my pain.
- ❑ My social life is normal, but it increases my level of pain.
- ❑ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- ❑ Pain prevents me from going out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of my pain.

Traveling

- ❑ I can travel anywhere without increased pain.
- ❑ I can travel anywhere, but it increases my pain.
- ❑ My pain restricts my travel over 2 hours.
- ❑ My pain restricts my travel over 1 hour.
- ❑ My pain restricts my travel to short, necessary journeys under ½ hour.
- ❑ My pain prevents all travel except for visits to the physician, therapist, or hospital.

Employment/Homemaking

- ❑ My normal homemaking/job activities do not cause pain.
- ❑ My normal homemaking/job activities increase my pain, but I an still perform all that is required of me.
- ❑ I can perform most of my homemaking/job activities, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- ❑ Pain prevents me from doing anything but light duties.
- ❑ Pain prevents me from doing even light duties.
- ❑ Pain prevents me from performing any job or homemaking chore.