Patient history and self assessment questionnaire

Please take a few minutes to complete this form. This information will be very helpful in establishing a diagnosis and assist in developing a treatment plan for you. This information will be placed into your records and be maintained in strict confidence.

- Date:
- Occupation:
- Name:
- Age: Race:
- Height: Weight:
- Sex:
- Email Address:
- Do you smoke? ❑Y ❑N
- Is your present condition accident related? ❑Y ❑N
- Your general physician:
- Who referred you to us?
- Have you seen any specialist[1] for this condition in the past? ❑Y ❑N
  If yes, please list:
- Describe in your own words your reason for seeking this evaluation, the onset and evolution of your problem.

1 Chiropractor, Acupuncturist, Physical or Occupational Therapist, etc.)

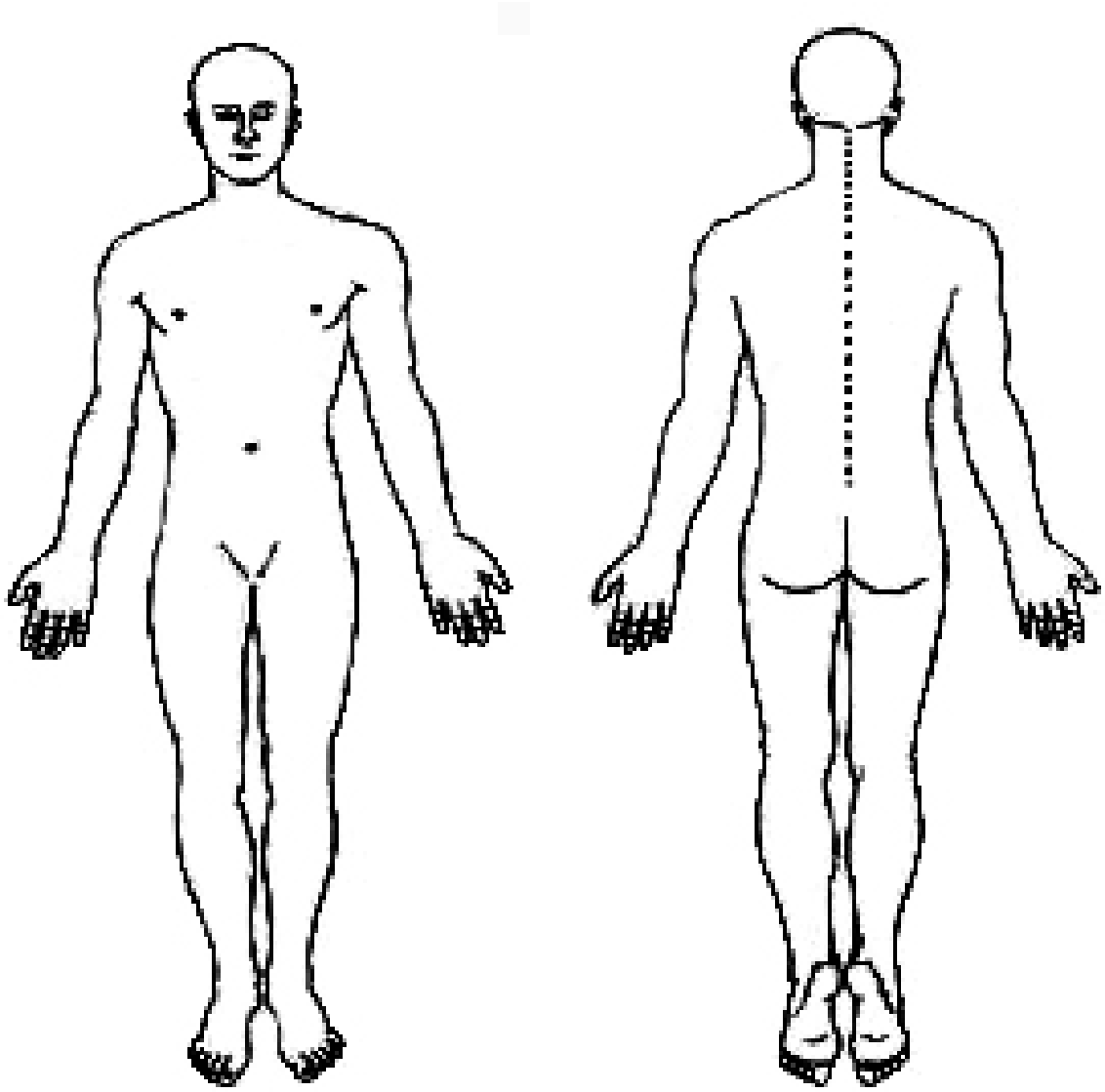
- Do you have any medical conditions? ❑Y ❑N
  If yes, please list
- Are you currently taking any medications? ❑Y ❑N
  If yes, please list t type and frequency:
- Do you have any allergies? ❑Y ❑N
  If yes, please list:
- How long have you had:
  - this pain: _____
  - spine problems: _____
- Have you been hospitalized for this condition ❑Y ❑N
- Have you had prior spine surgery? ❑Y ❑N
  If yes, please list:
  - Date of **all** prior surgery(ies): _____
  - How would you rate the relief of your prior surgery (0 being no relief, 10 being complete relief)?
    _____
  - How long was the duration of this relief?
    - ☐ 0-3 months
    - ☐ 3-6 months
    - ☐ 6-12 months
    - ☐ Greater than 1 year

Please indicate your pain on the scale below by marking an X on the lines:

No pain — Worst pain imaginable

0 — 10

Please mark areas of **Pain, Numbness**, **Tingling**, or **Weakness** on diagrams:



Modified Oswestry Low Back Pain Disability Questionnairea

This questionnaire has been designed to give your therapist information as to how your back 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. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity

- ❑ I can tolerate the pain I have without having to use pain killers.
- ❑ The pain is bad, but I can manage without taking pain killers.
- ❑ Pain killers give complete relief from pain.
- ❑ Pain killers give moderate relief from pain.
- ❑ Pain killers give little relief from pain.
- ❑ Pain give have no effect on my pain, I do not use them

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
- ❑ Pain prevents me from walking more than 1/2 mile.
- ❑ Pain prevents me from walking more than 1/4 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 1/2 hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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 1/2 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 medication, I sleep less than 4 hours.
- ❑ Even when I take medication, 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 form 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 1/2 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 can still perform all that is required of me.
- ❑ I can perform most of my homemaking / job duties, 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 chores.

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability. Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy*. 2001;81:776-788.

[a]Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy*. 1980;66:271-273.