Bone & Joint Specialists

LUMBAR

Name: _____ Age: _____ Date: _____

Please read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem *right now.***

SECTION 1 - **Pain Intensify**

- ☐ A. The pain comes and goes and is very mild.
- ☐ B. The pain is mild and does not very much.
- ☐ C. The pain comes and goes and is moderate.
- ☐ D. The pain is moderate and does not very much.
- ☐ E. The pain is severe but comes and goes.
- ☐ F. The pain is severe and does not vey much.

SECTION 2 - **Personal Care**

- ☐ A. I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ B. I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ C. Washing and dressing increase the pain, but I manage to change my way of doing it.
- ☐ D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ E. Because of the pain, I am unable to do any washing and dressing without help.
- ☐ F. Because of pain, I am unable to do any washing or dressing without help.

SECTION 3 - **Lifting**

- ☐ A. I can lift heavy weights without extra pain.
- ☐ B. I can lift heavy weights, but it causes extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor.
- ☐ D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- ☐ E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ F. I can only lift very little weights, at the most.

SECTION 4 - **Walking**

- ☐ A. Pain does not prevent me from walking any distance.
- ☐ B. I have some pain with walking but it does not increase with distance.
- ☐ C. Pain prevents me from walking more than one mile.
- ☐ D. Pain prevents me from walking more than ½ mile.
- ☐ E. I can only walk while using a cane or on crutches.
- ☐ F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - **Sitting**

- ☐ A. I can sit in any chair as long as I like without pain.
- ☐ B. I can only sit in my favorite chair as long as I like.
- ☐ C. Pain prevents me from sitting more than one hour.
- ☐ D. Pain prevents me from sitting more than ½ hour.
- ☐ E. Pain prevents me from sitting more than 10 minutes.
- ☐ F. Pain prevents me from sitting at all.

SECTION 6 - **Standing**

- ☐ A. I can stand as long as I want without pain.
- ☐ B. I have some pain while standing but it does not increase with time.
- ☐ C. I cannot stand for longer than one hour without increasing pain.
- ☐ D. I cannot stand for longer than ½ hour without increasing pain.
- ☐ E. I cannot stand for more than 10 minutes without increasing pain.
- ☐ F. I avoid standing because it increases pain right away.

SECTION 7 - **Sleeping**

- ☐ A. I get no pain in bed.
- ☐ B. I get pain in bed, but it does not prevent me from sleeping.
- ☐ C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- ☐ D. Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ F. Pain prevents me from sleeping at all.

SECTION 8 - **Social Life**

- ☐ A. My social life is normal and gives me no pain.
- ☐ B. My social life is normal, but increases the degree of my pain.
- ☐ C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ D. Pain had restricted my social life and I do not go out vey often.
- ☐ E. Pain has restricted my social life to my home.
- ☐ F. Pain prevents me from social life at all.

SECTION 9 - **Traveling**

- ☐ A. I get no pain while traveling.
- ☐ B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ E. Pain restricts all forms of travel.
- ☐ F. Pain prevents all forms of travel except that done lying down.

SECTION 10 - **Changing Degree of Pain**

- ☐ A. My pain is rapidly getting better.
- ☐ B. My pain fluctuates, but overall is definitely getting better.
- ☐ C. My pain seems to be getting better, but improvement is slow at present.
- ☐ D. My pain is neither getting better nor worse.
- ☐ E. My pain is gradually worsening.
- ☐ F. My pain is rapidly worsening.

LUMBAR index score: _____%

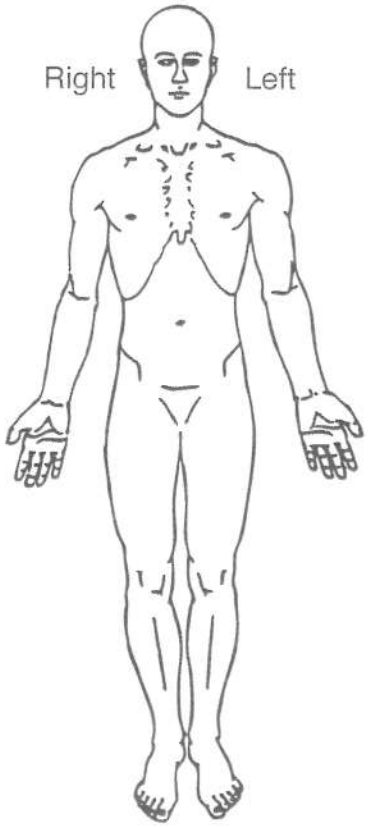
_____
Patient Signature

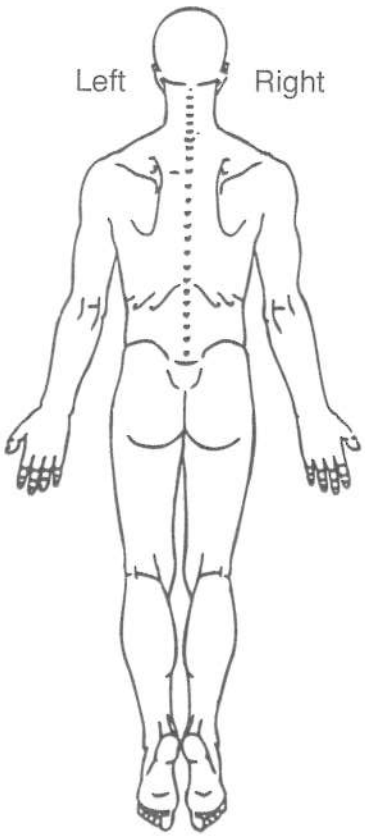
Bone & Joint Specialists

Patient Name: _____

Date: _____

Please mark an "X" on the body part(s) where you have pain.
Mark an "O" on the body parts where you have numbness.





NECK

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

BACK

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

RIGHT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

RIGHT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

LEFT ARM

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

LEFT LEG

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Pain Possible

Bone & Joint Specialists

REVIEW OF SYMPTOMS

In the past month, have you experienced any of the following?
Please put a check mark in front of any/all of the following that you have experienced.
If you have experienced any of the symptoms, please be sure to notify your family doctor.

H.E.E.N.T.

- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Hard of Hearing
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Cough
- ☐ Other _____

PULMONARY

- ☐ Shortness of Breath
- ☐ Other _____

ABDOMINAL

- ☐ Abdominal Pain
- ☐ Other _____

INTEGUMENTARY

- ☐ Moles
- ☐ Skin Rash
- ☐ Other _____

NEUROLOGIC

- ☐ Tremors
- ☐ Other _____

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Other _____

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Other _____

GENERAL

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Stress
- ☐ Poor Sleep
- ☐ Swelling of Feet
- ☐ Swollen Glands
- ☐ Problems with Blood Clots
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other _____

WORK STATUS

☐ Full Time ☐ Regular Duty

☐ Other _____

☐ Restrictions _____

Bone & Joint Specialists

Patient Name: _____

Date: _____

This form must be filled out at each office visit.
We are required to have documentation of medications and allergies for each office visit; because of this we are unable to accept "no change" or "same as before" answers on this form.

Medications Currently Taking: Dosage Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Pharmacy:

Name: _____

Address: _____

Phone: _____

Bone & Joint Specialists

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Birthplace: _____

Reason you are being seen here: ☐ Pain ☐ Disability ☐ Medication

Other: _____

Have you been seen here within the past 3 years? ☐ Yes ☐ No

Hand Dominance: ☐ Left ☐ Right

PAST MEDICAL HISTORY: *(Please check any/all of the following that you have experienced.)*

- ☐ AIDS
- ☐ Anemia
- ☐ Anxiety Problem
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disease
- ☐ Cancer
- ☐ Colon Polyp
- ☐ Congestive Heart Failure
- ☐ COPD/Emphysema
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Ear Trouble
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Fibromyalgia
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injury
- ☐ Heart Attack/Angina
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Polio
- ☐ Psychological/Psychiatric Problem
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Other Medical Problems: _____

Allergies: _____

Injuries: Please list all fractures, injuries, and motor vehicle accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury

Hospitalization/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery

Please continue on the other side

Have you ever had a blood transfusion? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you smoke now? ☐ Yes ☐ No _____ Packs per day

Did you smoke in the past? ☐ Yes ☐ No _____ Packs per day

Do you drink alcohol? ☐ Yes ☐ No _____ Drinks per week

Do you have a history of drug/alcohol abuse? ☐ Yes ☐ No

LEVEL OF EDUCATION:

☐ Grade School ☐ High School ☐ Graduate School ☐ Bachelor Degree ☐ Associate Degree

FAMILY HISTORY:

Please check the box of any/all of the following problems that your blood relatives (i.e. parents, brothers, sisters, grandparents, aunts, uncles, children) have had:

Illness	Relative/Family Member (i.e. Mom, Grandfather)
☐ Arthritis	
☐ Back or Neck Surgery	
☐ Back Pain/Sciatica	
☐ Cancer	
☐ Diabetes	
☐ Heart Attack/Heart Disease	
☐ High Blood Pressure	
☐ Mental Illness	
☐ Muscle Disease	
☐ Neck Pain	
☐ Nerve Disease	
☐ Stroke	

Relation	Age	State of Health	Medical Problems	Age At Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				

Patient Signature: _____

Bone & Joint Specialists

PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of years at this job: _____

Are you currently working? ☐ Yes ☐ No If yes: ☐ Part-time ☐ Full-time

☐ Regular Duty ☐ Modified Duty Working _____ Hours per week

What are your restrictions, if any? _____

_____

Does your job require you to: (please check all that apply)

☐ Lift or carry greater than 15 lbs. ☐ Bend or twist repetitively

☐ Work overhead ☐ Repetitive motion of the arms or legs

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date problem/symptoms started: _____

Location of symptoms/pain when the problem started: _____

HOW DID THE PROBLEM START?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall ☐ Other: _____

Please briefly describe: _____

Location of symptoms/pain now: _____

Frequency of symptoms/pain: (please check one) ☐ Constant ☐ Intermittent ☐ Rare

Since the onset of symptoms, has the problem: (please check one) ☐ Improved ☐ Worsened ☐ Stayed The Same

Does coughing or sneezing cause any pain? ☐ Yes ☐ No

If so, where? _____

Do any of the following activities make your symptoms worse? (please check all that apply)

☐ Walking ☐ Lying ☐ Bending/Twisting ☐ Working Overhead

☐ Sitting ☐ Kneeling ☐ Lifting/Carrying ☐ Other: _____

☐ Standing ☐ Typing ☐ Pushing/Pulling

List anything (i.e. activities, positions or treatments) that makes the pain better:

_____

Do you have any weakness, if so, which arm, leg or muscle? _____

Have you had any new or recurrent problems with: Control of urination? ☐ Yes ☐ No

Bowel movements? ☐ Yes ☐ No

Have you experienced recent weight loss or fevers? ☐ Yes ☐ No

Please continue on the other side

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

DIAGNOSTIC HISTORY:

TEST	RECEIVED	DATE OF TEST/LOCATION
X-ray	☐ Yes ☐ No	_____
MRI Scan	☐ Yes ☐ No	_____
CTScan	☐ Yes ☐ No	_____
Bone Scan	☐ Yes ☐ No	_____
EMG	☐ Yes ☐ No	_____
Other: _____	☐ Yes ☐ No	_____

MEDICATIONS *(If yes, please circle the medication below)*	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories	Naprosyn, Ibuprofen, Vioxx	☐ Yes ☐ No	☐ Yes ☐ No
Cox-2 Inhibitors	Voltaren, Celebrex, Bextra	☐ Yes ☐ No	☐ Yes ☐ No
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	☐ Yes ☐ No	☐ Yes ☐ No
Pain Medication	Tylenol w/Codeine, Vicodin, Darvocet Percocet	☐ Yes ☐ No	☐ Yes ☐ No
Oral Steroid	Prednisone, Medrol Dose Pak	☐ Yes ☐ No	☐ Yes ☐ No
Neurontin, Zonegram, Paxil, Amitriplyline, Nortriptyline, Pamelor, Elavil, Prozac		☐ Yes ☐ No	☐ Yes ☐ No
Other: Please list: _____		☐ Yes ☐ No	☐ Yes ☐ No

TREATMENTS	RECEIVED	DID THIS HELP?
Physical Therapy/Exercise	☐ Yes ☐ No	☐ Yes ☐ No
Chiropractic Care	☐ Yes ☐ No	☐ Yes ☐ No
Injections in muscle or other injections in office	☐ Yes ☐ No	☐ Yes ☐ No
Epidural Steroid Injections	☐ Yes ☐ No	☐ Yes ☐ No
Facet Blocks	☐ Yes ☐ No	☐ Yes ☐ No
Braces/Corsets	☐ Yes ☐ No	☐ Yes ☐ No

Back Surgery: ☐ Cervical ☐ Thoracic ☐ Lumber When: _____

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine?

☐ Yes ☐ No If yes, please list:

PHYSICIAN NAME	MONTH/YEAR OF TREATMENT
_____	_____
_____	_____
_____	_____

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ☐ Yes ☐ No

If yes, please list your attorney's name: _____

Patient Signature: _____