

LOW BACK PAIN

Oswestry Low Back Index

If you have LOW BACK pain, complete this page.

If you only have neck pain, skip this page.

This questionnaire enables us to understand how much neck pain has affected your ability to manage everyday activities. Please answer every section. Mark the one box 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 (washing, dressing, etc.)

- I can look after myself normally without causing extra 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 self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 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 walking more than 1 mile.
- Pain prevents me walking more than 1/2 mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit still in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me sitting more than 1/2 hour.
- Pain prevents me sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it causes extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

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

Section 8 – Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal, but causes some extra pain.
- My sex life is nearly normal, but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and causes me no extra 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 my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere, but it causes me extra pain.
- Pain is bad, but I can manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient's Name _____

Date _____

NECK PAIN

Oswestry Neck Index

If you have NECK pain, complete this page.

If you only have back pain, skip this page.

This questionnaire enables us to understand how much neck pain has affected your ability to manage everyday activities. Please answer every section. Mark the one box 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 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- 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 self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 very light weights.
- I cannot lift or carry anything at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Section 5 – Headaches

- I have no headache at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Section 10 – Recreation

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient's Name _____

Date _____



SPINE & SCOLIOSIS SPECIALISTS

ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408

Phone: (336) 333-6306 • Fax: (336) 333-6309

Date _____ Female / Male

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	None
1. Family History of Substance Abuse	Alcohol	[]	[]
	Illegal Drugs	[]	[]
	Prescription Drugs	[]	[]
2. Personal History of Substance Abuse	Alcohol	[]	[]
	Illegal Drugs	[]	[]
	Prescription Drugs	[]	[]
3. Age (Mark box if 16 - 45)		[]	[]
4. History of Preadolescent Sexual Abuse		[]	[]
5. Psychological Disease	Attention Deficit Disorder	[]	[]
	Obsessive Compulsive Disorder	[]	[]
	Bipolar	[]	[]
	Schizophrenia	[]	[]
	Depression	[]	[]



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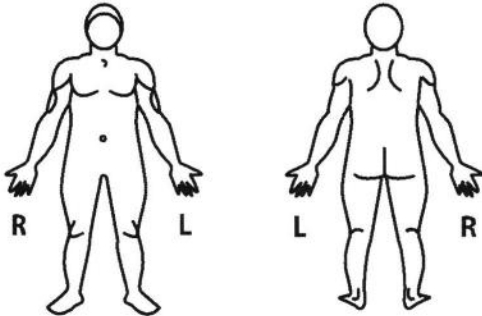
How did you hear about us? (Please check the appropriate box)

- Other patient Name _____
- By Doctor _____
- Website
- TV Ad
- Google Search
- Women's Journal
- Kernersville Magazine
- Kids Sports Play
- Henry Magazine
- Triad Magazine
- Newspaper
- High Point Hospital Hand Book
- Temple Emanuel Newsletter
- ABC TV 45 Website
- Outdoor Sign
- Spine Universe
- Spine Health
- Yellow Pages
- Attorney
- Website
- Triad Business Journal
- Other _____



FOLLOW-UP ASSESSMENT

Name: _____ DOB: _____ Primary Care Physician: _____ Date: _____



1. Please shade in only the area(s) of your pain that we are **seeing you for today.**

2. Status of pain since your last visit here:

Worse Better Same

3. Frequency: Constant Comes/Goes Rarely

4. Please indicate your level of pain:



5. Check the words that best describe the pain for which you are being seen:

Aching Burning Dull Numbing Sharp
 Cramping Radiating Stabbing Stinging Tingling

6. Please indicate which (if any) treatments you've had for the condition for which we are seeing you today.

Physical Therapy Chiropractic Care Medications Massage Injections*

*If yes to Injections, did you get relief? Yes No If yes, what percentage of relief? _____ %
 If yes, for how long? _____ minutes _____ hours _____ days _____ weeks _____ months

7. Are you working? Full Duty Light Duty Not Working

8. Since your last visit here, have you seen your Primary Care Physician, been hospitalized or had surgery?

➤ If yes, please explain:

9. Please check the activities that increase, decrease or do not change the pain for which we are treating you

<u>ACTIVITY</u>	<u>INCREASE PAIN</u>	<u>DECREASE PAIN</u>	<u>NO CHANGE</u>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing Positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaning Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Office Use Only:

10. Mark the following signs and/or symptoms you experience: If none apply, please check: None of these apply to me.

Constitutional:

- Chills
- Fatigue
- Fever
- Malaise
- Night sweats
- Weakness
- Weight gain
- Weight loss

Cardiovascular

- Chest pain
- Cyanosis
- Heart murmur
- Leg swelling
- Syncope
- Irregular heartbeat/
palpitations

Metabolic/Endocrine

- Cold intolerant
- Hair loss
- Heat intolerant

Integumentary

- Itchy skin
- Rash
- Skin infections
- Skin lesion

Hematologic

- Bleeding
- Bruising

HEENT

- Blurred vision
- Double vision
- Dysphagia
- Ear drainage
- Facial pain
- Headache

- Hearing loss
- Hoarseness
- Nasal congestion
- Ringing in ears
- Vertigo
- Vision loss

Gastrointestinal

- Abdominal pain
- Constipation
- Black tarry stools
- Diarrhea
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting

Neurological

- Difficulty walking
- Dizziness
- Poor coordination
- Memory impairment
- Muscle weakness
- Paresthesia
- Seizures
- Tremors

Respiratory

- Asthma
- Chest pain (respiratory)
- Cough
- Dyspnea
- Recent infections
- Known TB exposure
- Wheezing

Genitourinary

- Dysuria
- Frequent urination
- Hematuria
- Urge incontinence
- Urinary incontinence

Psychiatric

- Anxiety
- Depression
- Insomnia

Immunological

- Bee sting allergy
- Contact allergy
- Contact dermatitis
- Environmental allergies
- Food allergies
- Seasonal allergies

11. Have you been admitted to the hospital for any reason in the last 30 days? Yes No

➤ Discharge Date: _____

➤ Diagnosis: _____

12. Do you take blood thinners (including aspirin)? Yes No If yes, medication: _____

➤ Diagnosis: _____

13. Have you ever used tobacco products: Yes No Status: Current User Former User

14. Do you take medications for osteoporosis (brittle bones)? Yes No If yes, medication: _____

15. Do you take medications for high blood pressure? Yes No If yes, medication: _____

16. Have you received an influenza vaccine (flu): Yes No Date: _____ Best Estimate: _____

17. Have you received a pneumonia vaccine? Yes No Date: _____ Best Estimate: _____

18. Have you fallen in the last year? Yes No # of falls: _____ Did it result in injury? Yes No

Name: _____ Date: _____

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Family Hx Dx: Mother Father Sister Brother Dx: _____

Is pt. post op SSS? Yes No Surgery: _____

Assistive device? Cane Walker Rolling Walker Other _____

Provider:

50+ Does pt. have hip, spine/radius fx today? Yes No

If yes, refer to PCP, Dr. _____ for treatment of osteoporosis.

Is pt. at risk for falls? Yes No

65+ Balance/Strength/
Gait Training (circle) Advised PT Declined PT Home PT HEP N/A Other: _____

Address BMI: Did not counsel Child BMI Underweight

Hypertension >120/80: Diet Activity Referral _____

Tech: _____

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Section 7 – Sleeping

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Section 8 – Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal, but causes some extra pain.
- My sex life is nearly normal, but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and causes me no extra 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 my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere, but it causes me extra pain.
- Pain is bad, but I can manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient's Name _____

Date _____

NECK PAIN

Oswestry Neck Index

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- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

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- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

Section 5 – Headaches

- I have no headache at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient's Name _____

Date _____