ORTHOPEDIC INSTITUTE OF PENNSYLVANIA

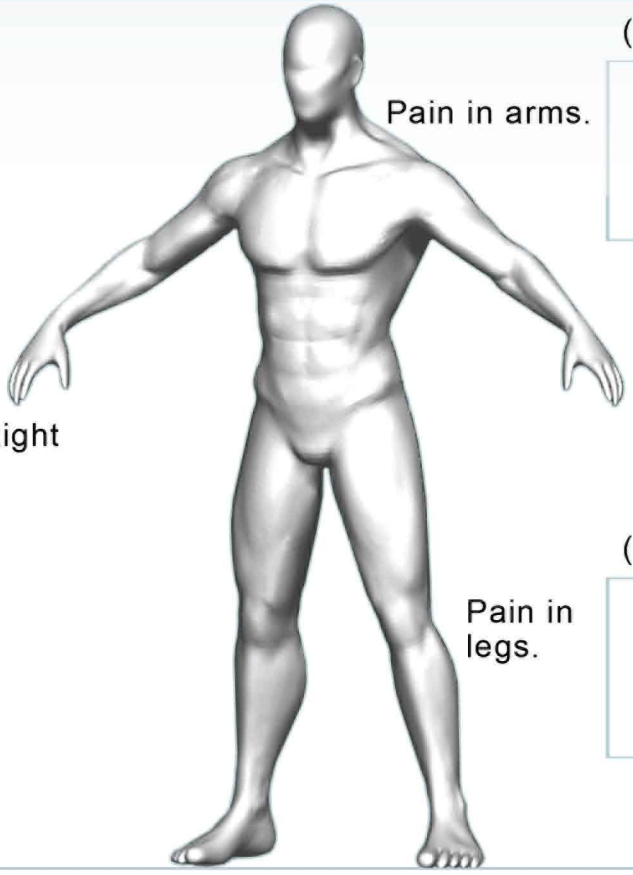
Dr. Wolf Back Pain Questionnaire Page #1

Name: _____ **Chart:** _____

Mark the areas on your body where you feel the described sensation.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

^^^^^^^ ^^^^^^^ ^^^^^^^ ^^^^^^^ ^^^^^^^	======= ======= ======= ======= =======	0000000 0000000 0000000 0000000	XXXXXXX XXXXXXX XXXXXXX XXXXXXX	/////// /////// /////// ///////
Ache	Numbness	Pins & Needles	Burning	Stabbing

Front



Right

Pain in arms.

(**circle one**)

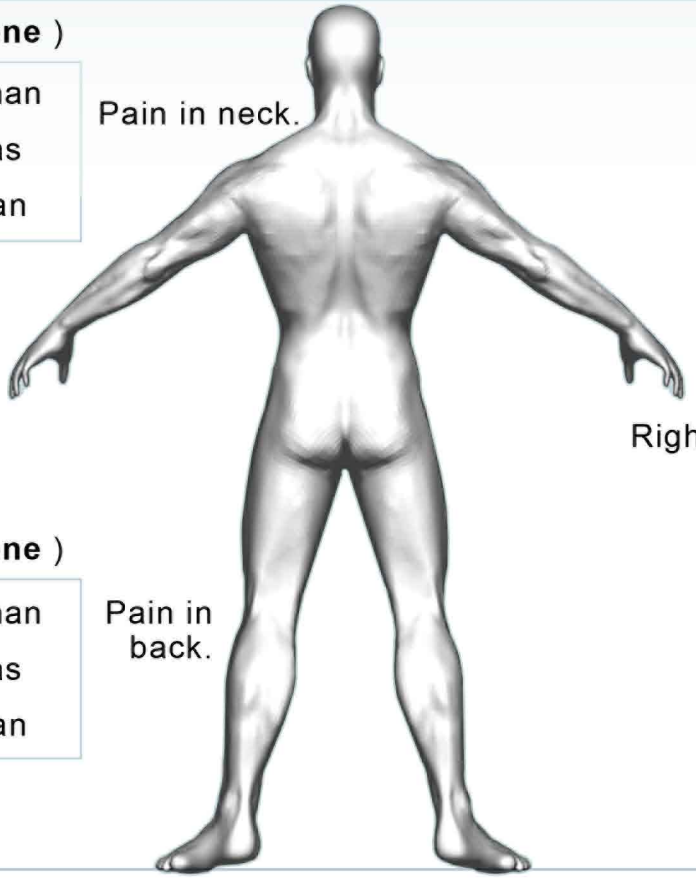
worse than
same as
less than

Pain in legs.

(**circle one**)

worse than
same as
less than

Back



Pain in neck.

Left

Right

Pain in back.

Rate your pain	0 = No pain									10 = Extremely intense
1. Right now	1	2	3	4	5	6	7	8	9	10
2. At its worst	1	2	3	4	5	6	7	8	9	10
3. At its best	1	2	3	4	5	6	7	8	9	10

Name: _____ Age: _____

Occupation: _____ Date: _____

1. What date (roughly at least) did your present pain start? _____

2. Mechanism of pain onset:

a.) Suddenly	( )	e.) Fall	( )	i.) Auto accident	( )
b.) Gradually	( )	f.) Bending	( )	j.) Hit in back	( )
c.) Lifting	( )	g.) Pulling	( )	k.) Sports	( )
d.) Twisting	( )	h.) Injured at work	( )	l.) No apparent cause	( )

3. What activities make the pain worse?

a.) During exercise	( )	d.) Standing	( )	g.) Bending backward	( )
b.) After exercise	( )	e.) Walking	( )	h.) Coughing	( )
c.) Sitting	( )	f.) Bending forward	( )	i.) Sneezing	( )

4. What reduces your pain?

a.) Lying down	( )	g.) Pain pills	( )
b.) Sitting	( )	h.) Muscle relaxant	( )
c.) Standing	( )	i.) Aspirin	( )
d.) Walking	( )	j.) Other _____	( )
e.) Manipulation	( )	k.) Nothing	
f.) Physical Therapy	( )		

5. How long have you had any back or neck pain? _____ years _____ months _____ weeks

6. Have you had any diagnostic studies other than by x-rays?

a.) CAT scan	_____ yes	_____ no	_____ date
b.) Myelogram	_____ yes	_____ no	_____ date
c.) EMG	_____ yes	_____ no	_____ date
d.) MRI	_____ yes	_____ no	_____ date
e.) Discogram	_____ yes	_____ no	_____ date

7. Have you been in the hospital for your back problem? _____ yes _____ no

   a. Number of times _____ b. Dates _____

8. Have you had neck or back surgery? _____ yes _____ no

   a. Number of times _____ b. Dates _____

9. Have you been in the hospital for other medical problems? _____ yes _____ no

   a. Number of times _____

   b. Describe _____

Name: _____

10. Please list current medications: _____

_____

_____

11. Do you take antacids? _____ yes _____ no

12. General medical problems:

a.) Stomach problems, ulcers, etc. ( )
b.) Diabetes ( )
c.) Arthritis ( )
d.) Gout ( )
e.) Sexual difficulties ( )
f.) Bowel or bladder ( )
g.) Cancer ( )
h.) Heart ( )
i.) Epilepsy ( )
j.) Other _____ ( )
k.) Loss of weight

13. Allergies:

14. Do you smoke? _____ yes _____ no How much _____

15. Do you drink alcoholic beverages? _____ yes _____ no How much _____

16. What other types of doctors have you seen for this condition? _____

_____

17. What other treatments / therapies / medications have you had for this problem?

_____

_____

18. Do you have any additional information that would be helpful in understanding your problem? Comments: _____

_____

_____

19. Employer's name and address: _____

_____

_____

20. To be sure any paperwork is filled out correctly, please check if appropriate:

( ) On workmans' compensation ( ) Receiving disability income

Name: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only ONE box which applies to you. We realize you may consider two of the statements in any one section relate to you, but please just MARK THE BOX WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM.

Section 1 - Pain Intensity

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

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 3 - Lifting

_____ I can lift heavy weight without extra pain.
_____ I can lift heavy weight but it gives extra pain.
_____ Pain prevents me from lifting heavy weight off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
_____ Pain prevents me from lifting heavy weight but I can manage light to medium weight if they are conveniently positioned.
_____ I can lift only very light weight.
_____ I cannot lift or carry anything at all.

Section 4 - Walking

_____ Pain does not prevent me walking any distance.
_____ Pain prevents me walking more than one (1) mile.
_____ Pain prevents me walking more than one half (1/2) mile.
_____ Pain prevents me walking more than one quarter (1/4) mile.
_____ I can only walk using a stick or crutches.
_____ I am in bed most of the time and have to crawl to the toilet.

Name: _____ Date: _____

Section 5 - Sitting

_____ I can sit in any chair as long as I like.
_____ I can sit only in my favorite chair as long as I like.
_____ Pain prevents me from sitting more than one (1) hour.
_____ Pain prevents me from sitting more than one half (1/2) hour.
_____ Pain prevents me from sitting more than ten (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 gives me extra pain.
_____ Pain prevents me from standing for more than one (1) hour.
_____ Pain prevents me from standing for more than thirty (30) minutes.
_____ Pain prevents me from standing for more than ten (10) minutes.
_____ Pain prevents me from standing at all.

Section 7 - Sleeping

_____ Pain does not prevent me from sleeping well.
_____ I can sleep well only by using medication.
_____ Even when I take medication I have less than six (6) hours sleep.
_____ Even when I take medication I have less than four (4) hours sleep.
_____ Even when I take medication I have less than two (2) hours sleep.
_____ Pain prevents me from sleeping at all.

Section 8 - Sex Life

_____ 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.

Name: _____ Date: _____

Section 9 - Social Life

_____ My social life is normal and gives 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. dancing, 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 my pain.

Section 10 - Traveling

_____ I can travel anywhere without extra pain.
_____ I can travel anywhere but it gives me extra pain.
_____ Pain is bad but I manage journeys over two hours.
_____ Pain restricts me to journeys of less than one hour.
_____ Pain restricts me to short necessary journeys under 30 minutes.
_____ Pain prevents me from traveling except to the doctor or hospital.

Comments: _____