CHRISTIANA SPINE CENTER

FOLLOW UP QUESTIONAIRE

TRC EGD AK NK STR FBS YIP AF AJ AM JM

Patient Name _____ **DOB** ___/___/___ **Date** _____

Primary Care Doctor Name_____

Please list any **NEW** medications that have been prescribed since your last visit. If no changes to your medications, please write **NO CHANGE**.

_____

Pharmacy name & phone #:_____

Are you currently working? _____ Your normal job? _____

What makes your pain worse: _____

What makes your pain better: _____

New allergies **OR** surgeries since your last visit: _____

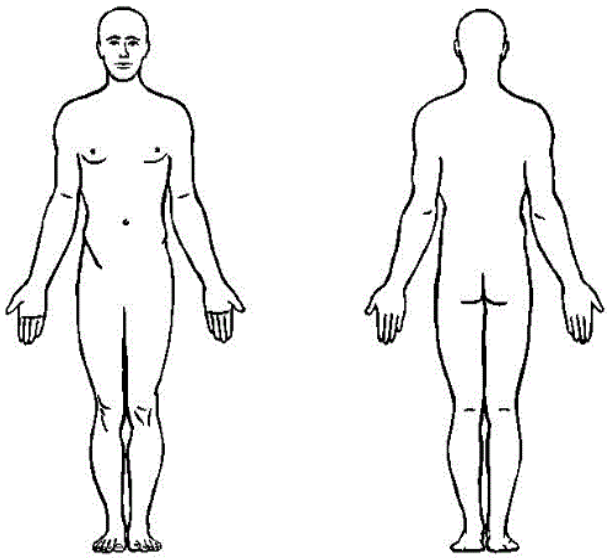
New accidents or injuries since your last visit? _____

Please circle any **concerns** that you have **today**:

Constitutional:	weight changes, weakness, fatigue, fever
Eyes:	blurred vision, double vision, glasses, tearing
ENT:	hearing, tinnitus, vertigo, sinus, cold, sore throat
Cardiovascular:	high blood pressure, murmurs, shortness of breath, chest pain, palpitations
Respiratory:	cough, sputum, wheezing, asthma, coughing w/ blood, bronchitis
Gastrointestinal:	difficulty swallowing, heartburn, indigestion, abdominal pain, blood in stool
Genitourinary:	pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence
Musculoskeletal:	joint pain, joint stiffness, cramps, neck pain, back of neck ache, weakness, loss of motion, low back pain, thoracic pain
Skin:	rash, lumps, itching, dryness, color changes, hair changes, nail changes
Neurological:	fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss
Psychological:	nervousness, tension, mood changes, depression, anxiety
Endocrine:	heat intolerance, cold intolerance, sweating, thirst, hunger, changes in urination
Hematology:	bruising, bleeding, transfusion reactions
Allergy/Immun:	drug allergies, product allergies, food allergies, childhood immunizations

(Please use your pen to mark painful areas)

Front **Back**



PROVIDER SIGNATURE:_____

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CHRISTIANA SPINE CENTER

Patient Name: _____ Date: _____

Oswestry Disability Questionnaire (FOR BACK PAIN ONLY)

This questionnaire has been designed to give us information as to how your back pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

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)
- 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 can 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 gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed i.e. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift light weights
- I cannot lift or carry anything

Section 4: Walking *
- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 0.5 miles
- Pain prevents me from walking more than 0.25 miles
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: 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 sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from 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 gives me extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for 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 have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- 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 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 i.e. sports
- 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 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 receive treatment

CHRISTIANA SPINE CENTER

Patient Name: _____ Date: _____

Disability Questionnaire (FOR NECK PAIN ONLY)

This questionnaire has been designed to give us information as to how your neck pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

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)

- 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 can 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 gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed i.e. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift light weights
- I cannot lift or carry anything

Section 4: Work

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

Section 5: Headaches

- I have no headaches 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 without difficulty
- I can concentrate fully with slight difficulty
- I have a fair degree of difficulty concentrating
- I have a lot of difficulty concentrating
- I have a great deal of difficulty concentrating
- I can't concentrate at all

Section 7: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed for less than 1 hour
- My sleep is mildly disturbed for up to 1-2 hours
- My sleep is moderately disturbed for up to 2-3 hours
- My sleep is greatly disturbed for up to 3-5 hours
- My sleep is completely disturbed for up to 5-7 hours

Section 8: Driving

- I can drive my car without neck pain
- I can drive as long as I want with slight neck pain
- I can drive as long as I want with moderate neck pain
- I can't drive as long as I want because of moderate neck pain
- I can hardly drive at all because of severe neck pain
- I can't drive my car at all because of neck pain

Section 9: Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of moderate neck pain
- I can't read as much as I want because of severe neck pain
- I can't read at all

Section 10: Recreation

- I have no neck pain during all recreational activities
- I have some neck pain with all recreational activities
- I have some neck pain with a few recreational activities
- I have neck pain with most recreational activities
- I can hardly do recreational activities due to neck pain
- I can't do any recreational activities due to neck pain