

LUMBAR SPINE QUESTIONNAIRE



Please take the time to answer the following question about your health. This form is important since it allows us to monitor your progress as we provide a treatment plan for you.

LUMBAR SPINE FORM

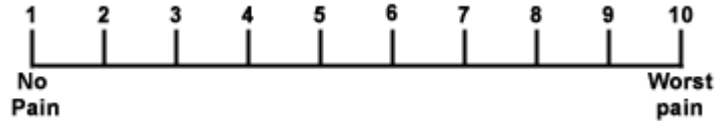
Name: _____

MRN: _____

Imprint Area DOB: _____

On a scale of 0 to 10 with *0=no pain* and *10=the worst possible pain*, what is your average pain level in your lower back?"

Back Pain



On a scale of 0 to 10 with *0=no pain* and *10=the worst possible pain*, what is your average pain level in your leg?"

Leg Pain



Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Oswestry Disability Index = _____ x 2 =

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities
For each of the following questions, please mark with an X the one box that best describes your answer.

1. In general, would you say your health is:

Excellent ▼ <input type="checkbox"/> 1	Very Good ▼ <input type="checkbox"/> 2	Good ▼ <input type="checkbox"/> 3	Fair ▼ <input type="checkbox"/> 4	Poor ▼ <input type="checkbox"/> 5
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2. Compared to 1 year ago, how would you rate your health in general now?

Much better than one year ago ▼ <input type="checkbox"/> 1	Somewhat better now than one year ago ▼ <input type="checkbox"/> 2	About the same as one year ago ▼ <input type="checkbox"/> 3	Somewhat Worse now than one year ago ▼ <input type="checkbox"/> 4	Much worse now than one year ago ▼ <input type="checkbox"/> 5
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3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot ▼ <input type="checkbox"/> 1	Yes, limited a little ▼ <input type="checkbox"/> 2	No, not limited at all ▼ <input type="checkbox"/> 3
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Lifting or carrying groceries.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Climbing <u>several</u> flights of stairs.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Climbing <u>one</u> flight of stairs.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Bending, kneeling, or stooping.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Walking <u>more than one mile</u>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. Walking <u>several blocks</u>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. Walking <u>one block</u>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. Bathing or dressing yourself.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. Cut down on the <u>amount of time</u> you spent on work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Were limited in the kind of work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Had <u>difficulty</u> performing the work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily problems (such as feeling depressed or anxious)?

	Yes	No
a. Cut down on the <u>amount of time</u> you spent on work or other activities.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. <u>Accomplished less</u> than you would like.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Did work or other activities less carefully than usual.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2

6. During the past 4 weeks, to what extent of your physical health or emotional problems interfered with your normal social activities with family, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very severe
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks.....

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
b. Have you felt so down in the dumps that nothing could cheer you up?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
c. Have you felt calm and peaceful?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
d. Did you have a lot of energy?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
e. Have you felt downhearted or blue?...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
f. Did you feel worn out?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
g. Have you been a happy person?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
h. Did you feel tired?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely TRUE	Mostly TRUE	Don't know	Mostly FALSE	Definitely FALSE
a. I seem to get sick a little easier than other people.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. I am as healthy as anybody I know.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. I expect my health to get worse.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. My health is excellent.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SF-36 Score _____