## General Information

Name: _____ Today's Date: _____ Age: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

## Reason for Visit – Current Condition

Briefly State the Reason for Today's Visit: _____

Is your condition a result of a(n): ☐ Auto Accident* ☐ Work Related Injury* ☐ Personal Injury* ☐ Not Sure

☐ Other (please explain): _____

*Please ask for and complete relevant questionnaire and agreement

**Date of Injury (or Date Problem First Noticed):** _____ Is this a new problem? ☐ Yes ☐ No

If **NO**, have you previously sought treatment? ☐ Yes ☐ No

If **YES**, who provided treatment: _____ City, State: _____

What did the previous treatment consist of, and what were the results? _____

_____

Are you currently experiencing any: ☐ weakness ☐ numbness ☐ radiating pain

Do you feel your condition is getting: ☐ better ☐ worse ☐ staying the same

Please **circle** the current severity of your pain from 0 (no pain) to 10 (most extreme pain):

0 1 2 3 4 5 6 7 8 9 10

## Past Medical History

Please list all previous surgeries, fractures, or serious illnesses:

| Date | Type of Surgery/Fracture/Illness | Date | Type of Surgery/Fracture/Illness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have **YOU** had (or currently have) any of the following (Please Check):

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Diabetes Type I | ☐ Heart Disease | ☐ Rheumatoid Arthritis |
| ☐ Asthma | ☐ Diabetes Type II | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Cancer | ☐ Epilepsy | ☐ Kidney Disease | ☐ Other _____ |
| ☐ Depression | ☐ Gout | ☐ Lung Disease | _____ |

## Medications

Please list ALL medications you are currently taking (prescription, over the counter, and herbal/nutritional supplements) as well as the route (i.e. oral, injectable, etc) taken:

| Medication | Dosage | Route | Medication | Dosage | Route |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

## Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage everyday life. Please answer by circling one selection 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 may apply but please make only one selection of the statement which most clearly describes your problem.

### Section 1: Pain Intensity

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate at the moment
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

### Section 2: Personal Care (e.g. washing, dressing)

0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but can manage most of my personal care
4 I need help every day in most aspects of self-care
5 I do not get dressed, I wash with difficulty and stay in bed

### Section 3: Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it gives me extra pain
2 Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (e.g. on a table)
3 Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything

### Section 4: Walking

0 Pain does not prevent me walking any distance
1 Pain prevents me from walking more than 1.25 miles
2 Pain prevents me from walking more than 0.625 miles
3 Pain prevents me from walking more than 0.3125 miles
4 I can only walk using a stick or crutches
5 I am in bed most of the time

### Section 5: Sitting

0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me for sitting more than one hour
3 Pain prevents me from sitting more than 30 minutes
4 Pain prevents me from sitting more than 10 minutes
5 Pain prevents me from sitting at all

### Section 6: Standing

0 I can stand as long as I want without extra pain
1 I can stand as long as I want but it gives me extra pain
2 Pain prevents me from standing for more than 1 hour
3 Pain prevents me from standing for more than 30 minutes
4 Pain prevents me from standing for more than 10 minutes
5 Pain prevents me from standing at all

### Section 7: Sleeping

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours of sleep
3 Because of pain I have less than 4 hours of sleep
4 Because of pain I have less than 2 hours of sleep
5 Pain prevents me from sleeping at all

### Section 8: Sex Life (if applicable)

0 My sex life is normal and causes no extra pain
1 My sex life is normal but causes some extra pain
2 My sex life is nearly normal but is very painful
3 My sex life is severely restricted by pain
4 My sex life is nearly absent because of pain
5 Pain prevents any sex life at all

### Section 9: Social Life

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant effect on my social life apart from limiting my more energetic interest (e.g. sports)
3 Pain has restricted my social life and I do not go out as often
4 Pain has restricted my social life to my home
5 I have no social life because of pain

### Section 10: Traveling

0 I can travel anywhere without pain
1 I can travel anywhere but it gives me extra pain
2 Pain is bad but I managed journeys over two hours
3 Pain restricts me to journeys of less than one hour
4 Pain restricts me to short necessary journeys under 30 minutes
5 Pain prevents me from traveling except to receive treatment

**SCORE** ☐

## Signature

**Patient (or Legal Guardian) Signature:** _____ **Date:** _____