



**Follow- Up Patient Questionnaire**  
**Comprehensive Spine Center**  
**Neurosurgery**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Is this a workman's compensation issue?    Yes    No

Where is your pain?

Has the pain changed at all since it began?    Yes    No

How would you describe the pain?

How bad is the pain, on average 0-10 \_\_\_\_\_ (0 is no pain, 10 the worst)

Do you have any of the following: (Circle Yes or No)

- |                                                              |     |    |
|--------------------------------------------------------------|-----|----|
| 1. Bowel or bladder accidents                                | Yes | No |
| 2. Numbness or weakness in arms or legs                      | Yes | No |
| 3. Pain that wakes you up out of a sleep                     | Yes | No |
| 4. Fever, chills, nausea, vomiting, weight gain, weight loss | Yes | No |
| 5. Increase in pain when coughing, sneezing, bowel movement  | Yes | No |

Have you had any tests (please circle)                      X-ray    MRI    CT scan    EMG

What medications are you taking for the pain now?

Review of Systems – Do you have any new problems/history with (Circle Yes or No; Explain)

- |                                                       |       |     |       |
|-------------------------------------------------------|-------|-----|-------|
| 1. Weight gain or loss, fever/chills?                 | No    | Yes | _____ |
| 2. Eyes/vision, ears, nose, throat?                   | No    | Yes | _____ |
| 3. Heart, arteries, blood pressure?                   | No    | Yes | _____ |
| 4. Lungs, breathing?                                  | No    | Yes | _____ |
| 5. Stomach, intestines, liver?                        | No    | Yes | _____ |
| 6. Kidneys, bladder?                                  | No    | Yes | _____ |
| 7. Bones, muscles, joints?                            | No    | Yes | _____ |
| 8. Strokes, seizures/epilepsy?                        | No    | Yes | _____ |
| 9. Depression, anxiety, other psychiatric conditions? | No    | Yes | _____ |
| 10. Bleeding disorders?                               | No    | Yes | _____ |
| 11. Diabetes, thyroid disease?                        | No    | Yes | _____ |
| 12. How is your sleep?                                | _____ |     |       |

| OFFICE USE ONLY |
|-----------------|
| Height          |
| Weight          |
| Blood Pressure  |
| Pulse           |
| Temperature     |
| Oswestry Score  |



MR #

Date of Service

## PAIN DRAWING

Name: \_\_\_\_\_

Age: \_\_\_\_\_

DOB: \_\_\_\_\_

### WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described discomfort using the appropriate symbols.

Just to complete the picture, please draw in your face.

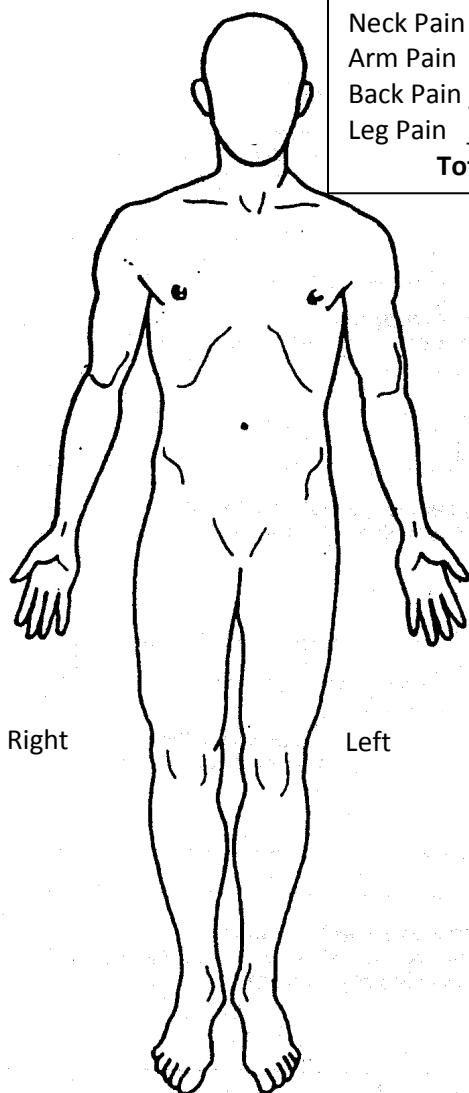
Ache ^^

Numbness OO

Pins & Needles ■■

Burning XX

Radiating Pain //



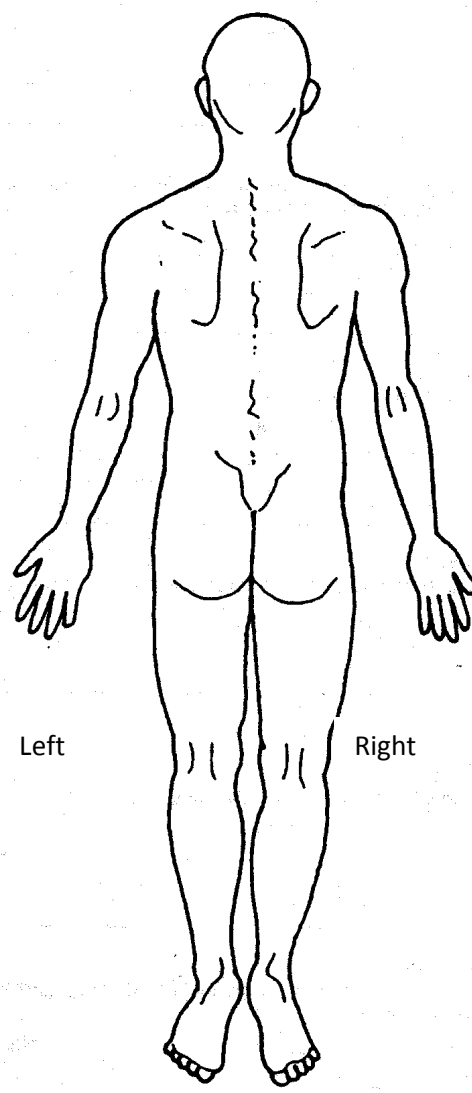
Neck Pain \_\_\_\_\_ %

Arm Pain \_\_\_\_\_ %

Back Pain \_\_\_\_\_ %

Leg Pain \_\_\_\_\_ %

**Total = 100%**



How bad is your pain now? PLEASE MARK ON THE LINE BELOW

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10

No pain

Intermediate Pain

Worst pain



# Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain

|   |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

Unbearable pain

Name \_\_\_\_\_ Date \_\_\_\_\_

**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.

TOTAL \_\_\_\_\_

## NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

### 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

- ☐ 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. I wash with difficulty and stay in bed.

### SECTION 3 - LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

### 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.

|       |                     |
|-------|---------------------|
| 0-4   | No disability       |
| 5-14  | Mild disability     |
| 15-24 | Moderate disability |
| 25-34 | Severe disability   |
| > 35  | Complete disability |