Back Patient History

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Medical Record Number

Date of Visit
/ /

First Name | Middle | Last Name | Suffix ○ Sr. ○ Jr. ○ III ○ IV ○ M.D. ○ PhD

Date of Birth
/ /
month day year (4 digit ex. 1922)

Gender
○ Female ○ Male

Race
○ African American ○ Asian ○ Caucasian ○ Hispanic ○ Native American ○ Other____________

Marital Status
○ Single ○ Married ○ Living with significant other ○ Divorced ○ Separated ○ Widowed

Location of Problem (What are you being seen for today?)
☐ Neck ☐ Low Back
☐ Right Shoulder ☐ Right Hip
☐ Left Shoulder ☐ Left Hip

Location of Your Worst Problem (Choose only ONE)
○ Neck ○ Low Back
○ Right Shoulder ○ Right Hip
○ Left Shoulder ○ Left Hip

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)
○ New Injury or problem (less than 6 weeks duration)
○ Subacute problem (began slowly with no identifiable cause and progressively worsened OR present 6 weeks to 3 months)
○ Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
○ Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)
/ /
month day year

Date of re-injury
/ /
month day year

Is your problem a result of an injury? ○ Yes ○ No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)
○ Home ○ Work ○ Motor vehicle accident ○ Exercise ○ Sport Competition ○ Other (specify)__________

What caused your injury?
☐ Fall ☐ Fighting
☐ Lifting ☐ Twisting
☐ Throwing ☐ Collision/Contact
☐ Reaching ☐ Other (specify)____________
☐ Pulling

Check any of the following that happened at the time of your injury
☐ Felt pain ☐ Heard popping ☐ Had swelling ☐ Dislocation ☐ Fracture ☐ Other (specify)___________

Have you talked to a lawyer concerning your problem? ○ Yes ○ No

Are you receiving or have you applied for workers compensation for your problem? ○ Yes ○ No

Have you received previous treatment for your current problem? ○ Yes ○ No

*If yes, please specify treatment type **(check all that apply)** and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today*

☐ ER Visit
☐ oral medicine
☐ physical therapy # of weeks
☐ surgical # of surgeries
☐ injections # of injections
☐ chiropractic
☐ massage therapy
☐ acupuncture
☐ other______________
(specify)

Please tell us your height and weight Height ft inches Weight pounds

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Primary Care/Family Physician (write only first and last name, do not write "Dr.")

Referring Physician (write only first and last name, do not write "Dr.")

Review of Systems

Please check all problems you currently experience - You may check more than one answer for each category.
If a problem does not apply to you DO NOT put any marks in the box.

☐ **Check this box if none of the following symptoms apply to you**

Overall General Health

☐ recent weight gain
☐ recent weight loss
☐ appetite change
☐ difficulty sleeping

Endocrine & Metabolic

☐ sugar diabetes
☐ goiter
☐ thyroid problem
☐ cholesterol / lipid problem

Blood (Hematopoietic / Lymphatic)

☐ anemia
☐ lymph node enlargement
☐ bleeding problem
☐ frequent infections

Psychiatric

☐ anxiety
☐ depression
☐ been seen by a psychiatrist

Lungs (Respiratory)

☐ shortness of breath
☐ cough
☐ sputum
☐ bronchitis
☐ asthma
☐ night sweats

Brain, Nerves, Spinal Cord (Neurologic)

☐ headaches
☐ dizziness
☐ blackouts
☐ numbness and tingling
☐ paralysis
☐ convulsions / seizures
☐ coordination trouble

Kidney, Bladder, Reproductive (Genitourinary)

☐ burning on urination
☐ frequency of urination
☐ difficulty starting urine
☐ wetting pants or bed
☐ bloody urine
☐ sexual difficulties

Heart & Blood Vessels (Cardiovascular)

☐ chest pain
☐ heart attack
☐ palpitations (irregular heart beat)
☐ heart failure
☐ edema (leg swelling)
☐ high blood pressure
☐ leg cramps with walking

Abdomen (Gastrointestinal)

☐ heartburn / indigestion
☐ difficulty swallowing
☐ stomach pains
☐ ulcers
☐ nausea / vomiting
☐ diarrhea
☐ hemorrhoids
☐ rectal bleeding
☐ black bowel movements
☐ change in bowel habits
☐ constipation
☐ frequent laxative use
☐ jaundice or hepatitis
☐ liver trouble
☐ gallbladder problems

Bone & Joint (Musculoskeletal)

☐ joint pain
☐ joint swelling or warmth
☐ joint stiffness
☐ muscle pain
☐ weakness
☐ back pain
☐ joint deformity

IN ORDER TO INSURE PROPER AND COMPREHENSIVE CARE, YOU MUST FOLLOW-UP WITH YOUR PRIMARY CARE PHYSICIAN FOR ANY AND ALL MEDICAL PROBLEMS AND CONCERNS CHECKED HERE

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- Please check any of the following conditions you have or have had in the past.
- If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems ☐ no medical problems

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis - rheumatoid (verified with blood test)
- ☐ Arthritis - osteo, degenerative
- ☐ Blood Clot Year ____
- ☐ Blood Transfusion Year ____
- ☐ Bowel disease
- ☐ Cancer (specify)________________
- ☐ Cardiac Arrhythmia (Abnormal heart rate)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease (Angina)
- ☐ Cerebrovascular Disease (Stroke)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Diabetes
- ☐ Depression
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack Year ____
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypercholesterolemia (Elevated Cholesterol)
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disorder - Cirrhosis
- ☐ Liver Disorder - Hepatitis
- ☐ Lung Disease
- ☐ Osteomyelitis
- ☐ Parkinson's
- ☐ Ulcer Disease
- ☐ Other (specify all other)____________

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? ○ Yes ○ No

Ear, Nose, Throat Surgeries — Year

- ☐ Deviated Septum ____
- ☐ Sinus Repair ____
- ☐ Tonsillectomy ____
- ☐ Tracheostomy ____
- ☐ Vocal Cord Surgery ____

Gastrointestinal Surgeries

- ☐ Appendectomy ____
- ☐ Cholecystectomy (Gallbladder removed) ____
- ☐ Colon Resection ____
- ☐ Exploratory Laparoscopy ____
- ☐ Hernia ○ Femoral ○ Incisional ○ Inguinal ○ Umbilical ____
- ☐ Liver Resection ____
- ☐ Small Bowel Obstruction Repair ____
- ☐ Splenectomy ____

Gynecologic Surgeries

- ☐ Hysterectomy ____
- ☐ Oophorectomy ____
- ☐ Ruptured ectopic ____
- ☐ Laparoscopy ____
- ☐ C-Section ____

Urologic Surgeries

- ☐ Bladder Suspension ____
- ☐ Bladder Removed ____
- ☐ Lithotripsy (Stone Machine) ____
- ☐ Prostatectomy (Prostate Removed) ____
- ☐ Vasectomy ____

General Surgeries — Year

- ☐ Breast Biopsy ○ Right ○ Left ○ Bilateral ____
- ☐ Mastectomy ○ Right ○ Left ○ Bilateral ____
- ☐ Thyroid Surgery ____
- ☐ Whipple ____

Heart (Cardiac) Surgeries

- ☐ CABG # arteries ○ 1 ○ 2 ○ 3 ○ 4 ○ 4+ ____
- ☐ Valve ☐ Aortic ☐ Mitral ☐ Tricuspid ____
- ☐ Angioplasty ____
- ☐ Defibrillator ____
- ☐ Pace Maker ____

Vascular Surgeries

- ☐ Bypass Graft - Legs ____
- ☐ Vascular Access ____
- ☐ AAA ____
- ☐ Thoracic Aneurysm ____

Thoracic Surgeries

- ☐ Chest Tube ____
- ☐ Pulmonary ____
- ☐ Pectus ____

Neurosurgeries

- ☐ Brain Tumor ○ Malignant ○ Benign ____
- ☐ Brain Aneurysm ____
- ☐ Chiari Decompression ____
- ☐ Spinal Cord Tumor ○ Malignant ○ Benign ____
- ☐ Epidural Injection ____
- ☐ Abcess ____
- ☐ Stent ____

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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year | Previous Surgery Year (if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Fracture Repair - Finger	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Hand	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Wrist	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Arm	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Elbow	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Shoulder	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Hip/Pelvis	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Femur	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Knee	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Lower Leg	○ Right ○ Left ○ Bilateral		
☐ Fracture Repair - Ankle/Foot	○ Right ○ Left ○ Bilateral		

Ankle/Foot Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Ankle Arthroscopy	○ Right ○ Left ○ Bilateral		
☐ Ankle Fusion	○ Right ○ Left ○ Bilateral		
☐ Tendon Surgery	○ Right ○ Left ○ Bilateral		
☐ Toe Surgery specify ____________	○ Right ○ Left ○ Bilateral		

Elbow, Wrist, Hand Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Biceps Repair	○ Right ○ Left ○ Bilateral		
☐ Carpal Tunnel Surgery	○ Right ○ Left ○ Bilateral		
☐ Elbow Arthroscopy	○ Right ○ Left ○ Bilateral		
☐ Elbow Ligament Reconstruction	○ Right ○ Left ○ Bilateral		
☐ Elbow Replacement	○ Right ○ Left ○ Bilateral		
☐ Hand Tendon Repair	○ Right ○ Left ○ Bilateral		
☐ Nail Bed Surgery	○ Right ○ Left ○ Bilateral		
☐ Tennis Elbow Surgery	○ Right ○ Left ○ Bilateral		
☐ Trigger Finger Surgery	○ Right ○ Left ○ Bilateral		
☐ Wrist Ligament Reconstruction	○ Right ○ Left ○ Bilateral		

Knee Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Knee Arthroscopy	○ Right ○ Left ○ Bilateral		
☐ Cartilage surgery/meniscus surgery	○ Right ○ Left ○ Bilateral		
☐ Knee replacement	○ Right ○ Left ○ Bilateral		
☐ Ligament reconstruction - ACL	○ Right ○ Left ○ Bilateral		
☐ Ligament reconstruction - other	○ Right ○ Left ○ Bilateral		

Hip Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Hip replacement	○ Right ○ Left ○ Bilateral		
☐ AVN Surgery ○ Core Decompression ○ Fibular Graft	○ Right ○ Left ○ Bilateral		

Shoulder Surgeries

Procedure	Side	Most Recent Year	Previous Surgery Year
☐ Shoulder Arthroscopy	○ Right ○ Left ○ Bilateral		
☐ Rotator cuff surgery	○ Right ○ Left ○ Bilateral		
☐ Shoulder replacement	○ Right ○ Left ○ Bilateral		
☐ Shoulder stabilization	○ Right ○ Left ○ Bilateral		

Spine Surgeries

Procedure	Level	Most Recent Year	Previous Surgery Year
☐ Laminectomy	☐ Cervical ☐ Lumbar ☐ Thoracic		
☐ Anterior Fusion	☐ Cervical ☐ Lumbar ☐ Thoracic		
☐ Posterior Fusion	☐ Cervical ☐ Lumbar ☐ Thoracic		
☐ Posterior Discectomy	☐ Cervical ☐ Lumbar ☐ Thoracic		

Other (List all other surgeries) ____

____

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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? ○ Yes ○ No *If yes, describe*________________________________

Are you allergic to latex? ○ Yes ○ No

Are you allergic to any medications? ○ Yes ○ No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other______________________

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other______________________

Specify Drug:

Describe: ☐ shock ☐ breathing problems ☐ rash ☐ nausea ☐ other______________________

Please list additional drug allergies here: ____

____

Please check any anti-inflammatory medication listed below which you have taken in the past.

☐ Advil
☐ Aleve
☐ Arthrotec
☐ Bextra
☐ Celebrex
☐ Daypro
☐ Ibuprofen
☐ Indocin
☐ Lodine
☐ Naprelan
☐ Naproxen
☐ Oruval/Orudis
☐ Ultram

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

☐ nausea ☐ diarrhea ☐ gastric ulcers ☐ upset stomach ☐ vomiting ☐ other_________________

Please check any of the following medications you take on a regular basis.

☐ Aspirin ☐ Axid ☐ Coumadin ☐ Cytotec ☐ Heparin ☐ Maalox ☐ Mylanta ☐ Pepcid ☐ Prevacid ☐ Prilosec ☐ Tagamet ☐ Zantac

List all medications you are currently taking with the correct dosage and frequency *(prescription and non-prescription medication)*

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Family Medical History

Please check all diseases for which you have a family history:

☐ Cancer - Breast
☐ Cancer - Prostate
☐ Cancer - Other
☐ Diabetes
☐ Heart Disease
☐ Stroke
☐ Rheumatoid Arthritis
☐ Arthritis - osteo, degenerative

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father ○ alive ○ deceased Age (current age or age deceased)

Health history ☐ cancer ☐ heart disease ☐ stroke ☐ diabetes ☐ rheumatoid arthritis ☐ osteoarthritis

Cause of death (if deceased)

Mother ○ alive ○ deceased Age (current age or age deceased)

Health history ☐ cancer ☐ heart disease ☐ stroke ☐ diabetes ☐ rheumatoid arthritis ☐ osteoarthritis

Cause of death (if deceased)

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Social History

Current Employment (Check only ONE answer)
- ○ full time
- ○ part time
- ○ retired
- ○ student
- ○ unemployed
- ○ paid leave
- ○ unpaid leave
- ○ disabled by back/neck
- ○ disabled by today's problem
- ○ disabled NOT by today's problem

Level of Education (Check only ONE answer)
- ○ grade school
- ○ high school/equivalent
- ○ some college
- ○ college degree
- ○ graduate degree

Job Title

Alcohol
- ○ I drink alcohol
- ○ I do not drink alcohol, but I used to drink alcohol
- ○ I never drank alcohol

If you drink alcohol, how frequently?
- ○ rarely (less than 1 drink a month)
- ○ occasionally (1-4 drinks per month)
- ○ socially (1-2 drinks per week)
- ○ frequently (3-5 drinks per week)
- ○ daily (at least one drink a day)

Tobacco
- ○ I use tobacco
- ○ I do not use tobacco, but I used to use tobacco
- ○ I have never used tobacco

If you use or used to use tobacco, cigarette packs per day
- ☐ 1/2
- ☐ 1
- ☐ 1 and 1/2
- ☐ 2
- ☐ 2 and 1/2
- ☐ 3
- ☐ 3 and 1/2
- ☐ 4

Years of tobacco use

Do you exercise regularly?

○ Yes ○ No

If you exercise, how often?

○ daily ○ 3 times per week ○ weekly ○ at least once every other week

Symptoms and Pain Survey

Duration of current symptoms:
- ○ no current symptoms
- ○ <1 week
- ○ 1-3 weeks
- ○ 3-6 weeks
- ○ 6 weeks-3months
- ○ 3-6months
- ○ 6months-1year
- ○ 1-3 years
- ○ 3-5 years
- ○ >5 years

Compared to 3 months ago, how would you rate your symtoms now?

○ much worse ○ a little worse ○ same ○ a little better ○ much better

Compared to 3 months ago, how worried are you about your condition now?

○ much less worried ○ less worried ○ no change ○ more worried ○ much more worried

Are you having pain today? ○ yes ○ no

Is your pain today - ○ occasional ○ continuous/constant

On a scale of 0-10 (with 10 being the worst pain imaginable), how would you score your pain today?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Check the words that best describe the character of the pain you are having today.
- ☐ aching
- ☐ throbbing
- ☐ shooting
- ☐ stabbing
- ☐ gnawing
- ☐ sharp
- ☐ tender
- ☐ burning
- ☐ exhausting
- ☐ tiring
- ☐ penetrating
- ☐ nagging
- ☐ numb
- ☐ miserable
- ☐ unbearable

Does the pain awaken you from sleep?

○ never ○ occasionally ○ frequently

Does the pain keep you from sleeping?

○ never ○ occasionally ○ frequently

What time of day is your pain worst (CHECK ONLY ONE)?

○ morning ○ afternoon ○ evening ○ nighttime ○ all the time

What makes your pain better?
- ☐ rest
- ☐ medication
- ☐ ice
- ☐ heat
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ standing
- ☐ nothing in particular
- ☐ other (specify)_________

What makes your pain worse?
- ☐ sitting
- ☐ standing
- ☐ lying down
- ☐ walking
- ☐ exercising
- ☐ activity in general
- ☐ stooping/bending
- ☐ nothing in particular
- ☐ other (specify)_________

If you had to spend the rest of your life with your condition the way it is now, how would you feel about it?

○ Delighted ○ Pleased ○ Mostly satisfied ○ Mixed ○ Mostly dissatisfied ○ Unhappy ○ Terrible

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Oswestry Back Survey

This questionnaire has been designed to give the doctor information as to how your 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 that two of the statements in any section relate to you, but please mark the box which most closely describes your problem.

How would you rate your back today as a percentage of normal (0% - 100%, with 100% being normal)? [ ][ ][ ] %

Section 1 - Pain Intensity

- ○ I can tolerate the pain without using pain killers
- ○ The pain is bad but I manage without taking pain killers
- ○ Pain killers give me complete relief from the pain
- ○ Pain killers give me moderate relief from the pain
- ○ Pain killers give me very little relief from the 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 any pain
- ○ I can look after myself normally but it causes 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 pain
- ○ I can lift heavy weights but it causes pain
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ○ I can lift very light weights
- ○ I cannot lift or carry anything at all

Section 4 - Walking

- ○ Pain does not prevent me from walking any distance
- ○ Pain prevents me from walking more than 1 mile
- ○ Pain prevents me from walking more than 1/2 mile
- ○ Pain prevents me from walking more than 1/4 mile
- ○ I can only walk using a cane or crutches
- ○ I am in bed most of the time and I have to crawl to the toilet

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 1 hour
- ○ Pain prevents me from sitting more than 1/2 hour
- ○ Pain prevents me from sitting more than 10 minutes
- ○ Pain prevents me from sitting at all

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Section 6 - Standing

○ I can stand as long as I like without pain
○ I can stand as long as I like but it gives me pain
○ Pain prevents me from standing more than 1 hour
○ Pain prevents me from standing more than 1/2 hour
○ Pain prevents me from standing more than 10 minutes
○ Pain prevents me from standing at all

Section 7 - Sleeping

○ Pain does not interfere with sleeping
○ I can sleep well only by taking medication
○ I can sleep <6 hours, even with medication
○ Even when I take medication I sleep <4 hours
○ Even with medication I sleep <2 hours
○ Pain prevents me from sleeping at all

Section 8 - Sex Life

○ My sex life is normal and causes no pain
○ My sex life is normal but causes pain
○ My sex life is 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

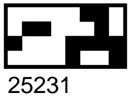
○ Pain does not interfere with my social life
○ My social life is normal, however, I experience some pain
○ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, ect.
○ Pain has restricted my social life and I do not go out as often
○ Pain has restricted my social life to my home
○ I have no social life because of the pain

Section 10 - Travelling

○ I can travel anywhere without pain
○ I can travel anywhere but it causes pain
○ The pain is bad but I manage journeys > 2 hours
○ The pain restricts me to journeys of less than 1 hour
○ Pain restricts me to short necessary journeys <30 minutes
○ Pain prevents me from travelling except to the doctor or hospital

How much bodily pain have you had during the past 4 weeks in the following areas?

	None	Very mild	Mild	Moderate	Severe	Very severe
a. neck	○	○	○	○	○	○
b. shoulder or arm	○	○	○	○	○	○
c. back	○	○	○	○	○	○
d. buttock	○	○	○	○	○	○
e. leg or foot	○	○	○	○	○	○
f. chest	○	○	○	○	○	○
g. abdomen	○	○	○	○	○	○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Hand Dominance: ○ **Right** ○ **Left** ○ **Use both equally**

SF-12 - Check ONLY ONE answer for each question

Instructions: 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. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

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

○ 1 Excellent ○ 2 Very good ○ 3 Good ○ 4 Fair ○ 5 Poor

(#2 and #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	Yes, Limited A Little	No, Not Limited At All
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
3. Climbing several flights of stairs	○ 1	○ 2	○ 3

(#4 and #5) 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
4. Accomplished less than you would like	○ 1	○ 2
5. Were limited in the kind of work or other activities	○ 1	○ 2

(#6 and #7) 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 any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. Accomplished less than you would like	○ 1	○ 2
7. Didn't do work or perform other activities as carefully as usual	○ 1	○ 2

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

○ 1 Not at all ○ 2 A little bit ○ 3 Moderately ○ 4 Quite a bit ○ 5 Extremely

(#9, #10 and #11) 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 one 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 time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
10. Did you have a lot of energy?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
11. Have you felt downhearted and blue?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

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

All of the time	Most of the time	Some of the time	A little of the time	None of the time
○ 1	○ 2	○ 3	○ 4	○ 5

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW