



15249

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, Arthritis - osteo, degenerative, Blood Clot, Blood Transfusion, Bowel disease, Cancer, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Artery Disease, Cerebrovascular Disease, COPD, Diabetes, Depression, Fibromyalgia, GERD, Gout, Heart Attack, Hypertension, Hypercholesterolemia, Hypothyroidism, Kidney Disease, Liver Disorder - Cirrhosis, Liver Disorder - Hepatitis, Lung Disease, Osteomyelitis, Parkinson's, Ulcer Disease, 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

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Ear, Nose, Throat Surgeries like Deviated Septum, Sinus Repair, Tonsillectomy, Tracheostomy, Vocal Cord Surgery.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Gastrointestinal Surgeries like Appendectomy, Cholecystectomy, Colon Resection, Exploratory Laparoscopy, Hernia, Liver Resection, Small Bowel Obstruction Repair, Splenectomy.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Gynecologic Surgeries like Hysterectomy, Oophorectomy, Ruptured ectopic, Laparoscopy, C-Section.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Urologic Surgeries like Bladder Suspension, Bladder Removed, Lithotripsy, Prostatectomy, Vasectomy.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes General Surgeries like Breast Biopsy, Mastectomy, Thyroid Surgery, Whipple.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Heart (Cardiac) Surgeries like CABG, Valve, Angioplasty, Defibrillator, Pace Maker.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Vascular Surgeries like Bypass Graft, Vascular Access, AAA, Thoracic Aneurysm.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Thoracic Surgeries like Chest Tube, Pulmonary, Pectus.

Table with 4 columns: Procedure name, Year 1, Year 2, Year 3, Year 4. Includes Neurosurgeries like Brain Tumor, Brain Aneurysm, Chiari Decompression, Spinal Cord Tumor, Epidural Injection, Abscess, 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

<input type="checkbox"/> Fracture Repair - Finger -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hand -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Wrist -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Arm -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Elbow -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Shoulder -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hip/Pelvis -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Femur -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Knee -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Lower Leg -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Ankle/Foot -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Ankle/Foot Surgeries

<input type="checkbox"/> Ankle Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ankle Fusion -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tendon Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Toe Surgery specify _____	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Elbow, Wrist, Hand Surgeries

<input type="checkbox"/> Biceps Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Carpal Tunnel Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Hand Tendon Repair -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Nail Bed Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tennis Elbow Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Trigger Finger Surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Wrist Ligament Reconstruction -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Knee Surgeries

<input type="checkbox"/> Knee Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Cartilage surgery/meniscus surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Knee replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - ACL -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - other -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Hip Surgeries

<input type="checkbox"/> Hip replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> AVN Surgery <input type="radio"/> Core Decompression <input type="radio"/> Fibular Graft	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Shoulder Surgeries

<input type="checkbox"/> Shoulder Arthroscopy -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Rotator cuff surgery -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder replacement -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder stabilization -----	<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral -----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Spine Surgeries

<input type="checkbox"/> Laminectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Anterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Fusion -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Discectomy -----	<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Other (List all other surgeries) _____

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:

Grid for specifying drug name: 30 empty boxes.

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Grid for specifying drug name: 30 empty boxes.

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Grid for specifying drug name: 30 empty boxes.

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

Please check any of the medications listed below which you have taken in the past.

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

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)

Three horizontal lines for listing current medications.

Family Medical History

Please check all diseases for which you have a family history: Family health history is unknown

- Cancer - Breast Heart Disease
 Cancer - Prostate Stroke
 Cancer - Other Rheumatoid Arthritis
 Diabetes 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 diabetes
 heart disease rheumatoid arthritis
 stroke osteoarthritis

Grid for father's health history: 30 empty boxes.

Mother alive deceased Age (current age or age deceased) [] [] [] Health history cancer diabetes
 heart disease rheumatoid arthritis
 stroke osteoarthritis

Grid for mother's health history: 30 empty boxes.

Hand Dominance: Right Left Use both equally**Oswestry Back Survey**

This questionnaire has been designed to give the doctor information as to how your **back** 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

**SF-36 - Check ONLY ONE answer for each question****SF-36v1™ Survey: Standard Self Report for Your Health and Well Being**

Answer all 11 questions. Some questions may look like others, but each one is different.

Please take the time to read and answer each question carefully, and mark the one box that best describes your answer.

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

- Excellent Very good Good Fair Poor

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago Somewhat better now than one year ago About the same as than one year ago Somewhat worse now than one year ago Much worse now than one year ago
-

3. The following questions 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
<u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing <u>several</u> flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing <u>one</u> flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>more than a mile</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>several blocks</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking <u>one block</u>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. During the past 4 weeks, how much of the time 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
Cut down on the <u>amount of time</u> , you spent on work or other activities	<input type="radio"/>	<input type="radio"/>
<u>Accomplished less</u> than you would like	<input type="radio"/>	<input type="radio"/>
Were limited in the <u>kind</u> of work or other activities?	<input type="radio"/>	<input type="radio"/>
Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort)	<input type="radio"/>	<input type="radio"/>

5. During the past 4 weeks, how much of the time 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)?

Cut down on the <u>amount of time</u> , you spent on work or other activities	<input type="radio"/>	<input type="radio"/>
<u>Accomplished less</u> than you would like	<input type="radio"/>	<input type="radio"/>
Didn't do work or other activities as <u>carefully as usual</u>	<input type="radio"/>	<input type="radio"/>



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

- Not at all Slightly Moderately Quite a bit Extremely

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

- None Very Mild Mild Moderate Severe Very Severe

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

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 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	Some of the time	A little of the time	None of the time
Did you feel full of pep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a very nervous person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a happy person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

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

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am as healthy as anybody I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect my health to get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My health is excellent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your **neck** 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 neck today as a percentage of normal (0% - 100%, with 100% being normal)? %

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, etc)

- 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 extra pain
- I can lift heavy weights but it gives extra 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 - Reading

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

Section 5 - Headaches

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all the time



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Section 6 - Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7 - Work

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

Section 8 - Driving

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

Section 9 - Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr. sleepless)
- My sleep is mildly disturbed (1-2 hrs. sleepless)
- My sleep is moderately disturbed (2-3 hrs. sleepless)
- My sleep is greatly disturbed (3-5 hrs. sleepless)
- My sleep is completely disturbed (5-7 hrs. sleepless)

Section 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW