

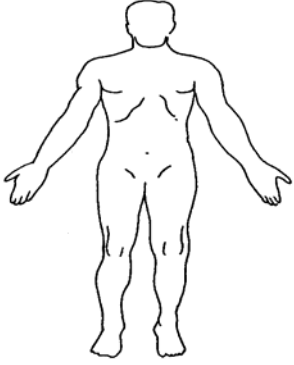
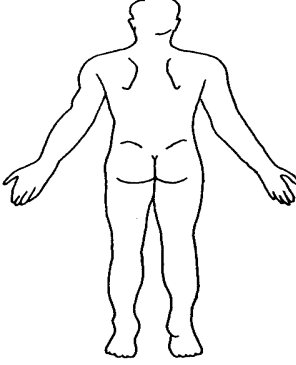
**NEW PATIENT QUESTIONNAIRE**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male Female

Height \_\_\_\_\_ Weight \_\_\_\_\_ ( ) Right- Handed ( ) Left- Handed Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 How would you describe yourself? African American Asian Caucasian Hispanic Middle Eastern Native American Pacific Islander Other: \_\_\_\_\_

**CURRENT SYMPTOMS** Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.  
 If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

sharp	 <p style="text-align: center;"><b>Front</b></p> <p>right left</p>	shooting	 <p style="text-align: center;"><b>Back</b></p> <p>left right</p>	burning
throbbing		electric-like		skin sensitivity to light touch, cold
cutting		pins and needles		abnormal swelling, hair/nail growth
dull, aching		weakness		abnormal sweating
pressure		numbness		abnormal skin color changes
muscle pain				abnormal skin temperature
cramping				limited movement

Please list your complaints in order of importance.

**Complaint #1:** \_\_\_\_\_

Do you have this pain: ( ) constantly (90-100% of the time), ( ) frequently (75%), ( ) intermittently (50%), ( ) occasionally (25%)

<b>Pain Intensity:</b> Circle your pain intensity with "0" representing no pain and "10" the most severe pain imaginable	Current	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	7 day average	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Least pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Worst pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe

What increases or decreases your pain?

Increase		Decrease
	Bending forward	
	Bending backwards	
	Sitting	
	Standing	
	Walking	
	Exercise	

Increase		Decrease
	Coughing or Straining	
	Bowel movements	
	Lying down	
	Pushing shopping cart	
	Relaxation	
	Medications (give names)	

**Complaint #2:** \_\_\_\_\_

Do you have this pain? ( ) constantly (90-100% of the time), ( ) frequently (75%), ( ) intermittently (50%), ( ) occasionally (25%)

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Pain Scale: current \_\_\_/10, 7 day average \_\_\_/10, 7 day least \_\_\_/10, 7 day worst \_\_\_/10

**Complaint #3:** \_\_\_\_\_

Do you have this pain: ( ) constantly (90-100% of the time), ( ) frequently (75%), ( ) intermittently (50%), ( ) occasionally (25%)

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Pain Scale: current \_\_\_/10, 7 day average \_\_\_/10, 7 day least \_\_\_/10, 7 day worst \_\_\_/10

If you have both back and leg pain: back is \_\_\_% of entire pain leg is \_\_\_\_\_% of entire pain

If you have both neck and arm pain: neck is \_\_\_% of entire pain arm is \_\_\_\_\_% of entire pain

How many blocks can you walk before having to stop because of pain? \_\_\_\_\_ blocks

**HISTORY OF PRESENT ILLNESS.** When did you first start having the pain? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

How did your symptoms start? \_\_\_\_\_ Suddenly \_\_\_\_\_ Gradually Over what period of time? \_\_\_\_\_

Are your symptoms related to an **injury**? NO YES If yes:  
Date of Injury \_\_\_ / \_\_\_ / \_\_\_\_\_ (mm/dd/yyyy) Time: \_\_\_\_\_ AM PM

Where did your injury occur? (Address or description of location): \_\_\_\_\_

The injury was Lifting Falling Twisting Whiplash Repetitive Strain Injury

Describe how your injury occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did you realize that you were injured? \_\_\_\_\_

**The injury was** Not Work Related Work Related

**If injury was WORK RELATED:** Did you report your injury to your employer/supervisor: \_\_\_\_\_ When: \_\_\_\_\_

Please list the injured body parts, as a result of your work injury: \_\_\_\_\_

Have you ever experienced the same or similar symptoms before this work injury? \_\_\_ Yes \_\_\_ No If "Yes", please explain: \_\_\_\_\_

Claim # \_\_\_\_\_ Claim status: Active Settled

Permanent & Stationary: NO YES If yes, when? \_\_\_ / \_\_\_ / \_\_\_\_\_ (mm/dd/yyyy)

Were you awarded Future Medical Benefits: NO YES

**Are your symptoms related to a MOTOR VEHICLE ACCIDENT (MVA)?** NO YES If "No", please go to next page:

**Accident Information:** Date of accident? \_\_\_\_\_ Time of day \_\_\_\_\_ am pm

Location of the accident: (street/city/highway/state/etc) \_\_\_\_\_  
\_\_\_\_\_

Direction you were headed? North South East West Direction of other vehicle? North South East West

Road condition: dry wet snowy icy slippery other \_\_\_\_\_

Area(s) of vehicle damaged? rear front driver side passenger side

How many vehicles were involved in the accident? \_\_\_\_\_

Were you the: driver; passenger front seat back seat on driver side in the middle on passenger side

Were you wearing a seat belt? NO YES Were you wearing a shoulder strap? NO YES

Does your vehicle have an airbag? NO YES If yes, did it inflate? NO YES

Was a traffic citation given? NO DON'T KNOW YES Who received the citation? \_\_\_\_\_

**History of the Accident:** Describe how the accident occurred (please be specific): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you lose consciousness? NO YES If yes, for how long? \_\_\_\_\_

At the time of the accident were you looking? straight ahead to the right to the left up down

Was your body turned? NO YES to the left YES to the right

**Was your vehicle:** stopped slowing down gaining speed moving at a steady speed

Estimate how fast your vehicle was traveling: \_\_\_\_\_ mph

What were the year, make and model of the vehicle you were in? Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

**Was the other vehicle?** stopped slowing down gaining speed moving at a steady speed

Estimate how fast the other vehicle was traveling: \_\_\_\_\_ mph

What were the year, make and model of the other vehicle? Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

Did your vehicle collide with anything? NO YES If yes, what? \_\_\_\_\_

Were you aware of the impending collision? NO YES Did you prepare yourself for the collision? NO YES  
If yes, how? \_\_\_\_\_

Did any of your body parts hit the interior of the car? NO YES If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Did anything in the car hit you? NO YES If yes, explain: \_\_\_\_\_

How many people were in your vehicle? \_\_\_\_\_. Besides you, was anyone else injured? NO YES If yes, who? \_\_\_\_\_  
\_\_\_\_\_

Any: cuts bruises scratches fractures? If yes, explain: \_\_\_\_\_

Damage to your vehicle? Mild Moderate Significant Totaled

**HISTORY OF TREATMENT**

If injured, were you treated at the scene? NO YES If yes, how? \_\_\_\_\_

Did you go to a hospital? NO YES If yes, when? \_\_\_\_\_

City? \_\_\_\_\_ Name of hospital? \_\_\_\_\_

If yes, did you get hospitalized? NO YES If yes, how long? \_\_\_\_\_

Name of the doctor who treated you? \_\_\_\_\_

Describe treatment and/or diagnostic testing: \_\_\_\_\_

What did that doctor say was wrong with you? \_\_\_\_\_

Please list all the doctors seen for this injury, other than at a hospital. List in the order seen:

**Name of doctor #1:** \_\_\_\_\_ Type of doctor? \_\_\_\_\_ City? \_\_\_\_\_

Describe treatment, tests, or referrals: \_\_\_\_\_

What did the doctor say was wrong with you? \_\_\_\_\_

Results of treatment? \_\_\_\_\_

Date of first treatment? \_\_\_\_\_ Last treatment? \_\_\_\_\_ Number of treatments? \_\_\_\_\_

Length of treatments? \_\_\_\_\_ Still being treated? NO YES If yes, how often? \_\_\_\_\_

**Name of doctor #2:** \_\_\_\_\_ Type of doctor? \_\_\_\_\_ City? \_\_\_\_\_

Describe treatment, tests, or referrals: \_\_\_\_\_

What did the doctor say was wrong with you? \_\_\_\_\_

Results of treatment? \_\_\_\_\_

Date of first treatment? \_\_\_\_\_ Last treatment? \_\_\_\_\_ Number of treatments? \_\_\_\_\_

Length of treatments? \_\_\_\_\_ Still being treated? NO YES If yes, how often? \_\_\_\_\_

**Name of doctor #3:** \_\_\_\_\_ Type of doctor? \_\_\_\_\_ City? \_\_\_\_\_

Describe treatment, tests, or referrals: \_\_\_\_\_

What did the doctor say was wrong with you? \_\_\_\_\_

Results of treatment? \_\_\_\_\_

Date of first treatment? \_\_\_\_\_ Last treatment? \_\_\_\_\_ Number of treatments? \_\_\_\_\_

Length of treatments? \_\_\_\_\_ Still being treated? ( )no, ( )yes If yes, how often? \_\_\_\_\_

Any other treatment, tests, therapy or examinations that have not been described? NO YES

If yes, explain: \_\_\_\_\_

Were you treated by any of these providers before? NO YES If yes, explain: \_\_\_\_\_

Do you treat your condition at home? NO YES If yes, explain: \_\_\_\_\_

Are you using ( ) brace, ( ) cane, ( ) crutches, ( ) wheelchair?

Has there been a recommendation of testing or treatment which you have not received? NO YES

What treatment(s) offer you the most relief? \_\_\_\_\_

**DISABILITY:** Has this illness affected your work performance? NO YES If yes, how? \_\_\_\_\_

Before developing this condition, how would you describe your health? Excellent Good Fair Poor  
If fair or poor, explain: \_\_\_\_\_

Activities you avoid because of pain: ( )going to work, ( )performing household chores, ( )doing yard work or shopping, ( )driving  
( )socializing, ( )participating in recreation, ( )having sexual relations, ( )exercising, ( )caring for self

Have you missed work or been placed on modified duty due to this condition? NO YES If yes, explain: \_\_\_\_\_

**PRIOR WORK INJURIES:** List in chronological order.

	Date	Injured body part(s)	Claim#	Status of the claim	Employer
1					
2					
3					

**PRIOR NON-WORK RELATED INJURIES:** List in chronological order.

	Date	Injured body part(s)	Claim#	Status of the claim	Employer
1					
2					
3					

Have you experienced the same or similar symptoms before the onset of this condition? NO YES. If yes, explain: \_\_\_\_\_

Have you received a **prior** disability award? NO YES If yes, explain: \_\_\_\_\_

Have you served in the military? NO YES If yes, did you receive a medical discharge? NO YES  
If yes, explain: \_\_\_\_\_

Have you suffered any new injuries to the body parts which were injured in the accident? NO YES  
If yes, explain: \_\_\_\_\_

**PAST MEDICAL HISTORY:** Have you ever had any of the following health problems?

<input type="checkbox"/> Diabetes Type I II	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/ AIDS
<input type="checkbox"/> Chest pain, heart attack	<input type="checkbox"/> Lupus	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Asthma, COPD	<input type="checkbox"/> Stroke (TIA)	<input type="checkbox"/> Seizure or epilepsy	<input type="checkbox"/> TB

Other medical problems:

1	5
2	6
3	7

List all surgeries (date and type of operation):

1. Laminectomy?	5.
2. Fusion?	6.
3.	7.

Are you pregnant? N/A NO Not sure YES \_\_\_\_\_

Are you on a special diet? NO YES If yes, please describe \_\_\_\_\_

Have you ever had any problems with anesthesia/sedation? NO YES (Please describe) \_\_\_\_\_

CURRENT MEDICATIONS	Dose	How many at a time	How many times a day	Benefits/ side effects	First Intake?	Last intake?	Refill needed?

Please check the medications that you are currently on. Indicate the dosage and number of pills you are taking per day. Cross out medications that you have tried in the past, indicate the reason for stopping.

NARCOTICS	ANTI-INFLAMMATORIES (NSAIDS)	ANTIDEPRESSANTS
<input type="checkbox"/> Codeine	<input type="checkbox"/> Aleve (Naproxen)	<input type="checkbox"/> Celexa
<input type="checkbox"/> Demerol (Meperidine)	<input type="checkbox"/> Celebrex	<input type="checkbox"/> Cymbalta
<input type="checkbox"/> Dilaudid (Hydromorphone)	<input type="checkbox"/> Feldene (Piroxicam)	<input type="checkbox"/> Elavil (Amitriptyline)
<input type="checkbox"/> Fentanyl (Duragesic patch)	<input type="checkbox"/> Ibuprofen (Motrin, Advil)	<input type="checkbox"/> Effexor (Venlafaxine)
<input type="checkbox"/> Levorphanol	<input type="checkbox"/> Indomethacin (Indocin)	<input type="checkbox"/> Desyrel (Trazodone)
<input type="checkbox"/> Lortab	<input type="checkbox"/> Lodine (Etodolac)	<input type="checkbox"/> Lexapro
<input type="checkbox"/> Methadone	<input type="checkbox"/> Naprosyn (Naproxen)	<input type="checkbox"/> Norpramin (Desipramine)
<input type="checkbox"/> Morphine /MS Contin	<input type="checkbox"/> Relafen (Nabumetone)	<input type="checkbox"/> Pamelor (Nortriptyline)
<input type="checkbox"/> Norco	<input type="checkbox"/> Toradol (Ketorolac)	<input type="checkbox"/> Paxil (Paroxetine)
<input type="checkbox"/> Nucynta	<b>SLEEPING PILLS</b>	<input type="checkbox"/> Prozac (Fluoxetine)
<input type="checkbox"/> Opana	<input type="checkbox"/> Ambien (Zolpidem)	<input type="checkbox"/> Serzone (Nefazodone)
<input type="checkbox"/> Oxycontin /Oxycodone	<input type="checkbox"/> Lunesta	<input type="checkbox"/> Sinequan (Doxepin)
<input type="checkbox"/> Percocet	<b>BLOOD THINNERS</b>	<input type="checkbox"/> Wellbutrin (Bupropion)
<input type="checkbox"/> Suboxone	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Zoloft (Sertraline)
<input type="checkbox"/> Tylenol with codeine	<input type="checkbox"/> Coumadin	<b>OTHERS</b>
<input type="checkbox"/> Vicodin (Hydrocodone)	<input type="checkbox"/> Plavix	<input type="checkbox"/> Lidoderm
	<b>ANTI-ANXIETY</b>	<input type="checkbox"/> Depakote (Valproic Acid)
	<input type="checkbox"/> Ativan (Lorezapam)	<input type="checkbox"/> Dilantin (Phenytoin)
<b>MUSCLE RELAXANTS</b>	<input type="checkbox"/> Buspar (Buspirone)	<input type="checkbox"/> Lamictal (Lamotrigine)
<input type="checkbox"/> Baclofen (Lioresal)	<input type="checkbox"/> Halcion (Triazolam)	<input type="checkbox"/> Lyrica
<input type="checkbox"/> Flexeril (Cyclobenzaprine)	<input type="checkbox"/> Klonopin (Clonazepam)	<input type="checkbox"/> Neurontin (Gabapentin)
<input type="checkbox"/> Robaxin (Methocarbamol)	<input type="checkbox"/> Serax (Oxazepam)	<input type="checkbox"/> Tegretol (Carbamezapine)
<input type="checkbox"/> Soma (Carisoprodol)	<input type="checkbox"/> Valium (Diazepam)	<input type="checkbox"/> Topomax (Topiramate)
<input type="checkbox"/> Zanaflex (Tizanidine)	<input type="checkbox"/> Xanax (Alprazolam)	<input type="checkbox"/> Ultram (Tramadol) Ultracet

**ALLERGIES** to medications (including antibiotics, local anesthetics, or materials):

latex			
x-ray contrast dye, iodine			

Review of Systems (Circle all that apply).

<b>General</b>	Fever Chills Unplanned weight loss Night sweats
<b>Eyes</b>	Glaucoma Double/blurred vision Blind spots
<b>Nose:</b>	Sinusitis Bleeding Congestion Runny nose Hearing loss
<b>Throat:</b>	Sore throat Difficulty swallowing Hoarseness Dentures Full/Partial Snoring
<b>Heart:</b>	Chest pain Previous heart attack Murmur Dizzy spells Congestive heart failure last six months
<b>Lungs:</b>	Wheezing Shortness of breath Cough Tuberculosis
<b>GI:</b>	Abdominal pain Heartburn Nausea Vomiting Diarrhea Constipation Incontinence Dark stools Rectal bleeding
<b>GU:</b>	Sexual dysfunction Urinary retention
<b>Musculoskeletal:</b>	Knee pain Shoulder pain Restricted movement
<b>Skin</b>	Rash Easy bruising/bleeding Lesions Abnormal hair loss Nail ridging, pitting
<b>Neurological:</b>	Seizures Dizziness Weakness Drowsiness Trouble walking Problems controlling bowel/ bladder
<b>Psychiatric:</b>	Difficulty falling or remaining asleep Excessive fatigue Feeling depressed Memory loss
<b>Endocrine:</b>	Heat / cold intolerance Diabetes Thyroid disorder
<b>Hematology:</b>	Easy bruising Low platelet count Enlarged lymph nodes

**FAMILY HISTORY** List all health problems in your family. (mom/dad/brother/sister) ( ) none

Alcohol addiction  Drug addiction  Back pain  Fibromyalgia  Migraine headaches  Psychiatric illnesses  Suicide

Present Physician(s) Name & City \_\_\_\_\_

Past Physician(s) Name & City \_\_\_\_\_

**JOB DESCRIPTION**

Who is your employer? \_\_\_\_\_ What is your job title? \_\_\_\_\_

What is the nature of your work? \_\_\_\_\_

When did you start working for this employer? \_\_\_\_\_

Employed ( ) Full-time ( ) Part-time \_\_\_\_ hrs/day, \_\_\_\_ days/week  
( ) Temporarily disabled ( ) Permanently disabled ( ) Retired

How many rest periods do you have per day? \_\_\_\_\_ How long are the rest periods? \_\_\_\_\_

How many hours per work day do you? Sit \_\_\_ stoop \_\_\_ walk \_\_\_ stand \_\_\_ kneel \_\_\_ squat \_\_\_ climb \_\_\_ bend \_\_\_ twist \_

Please list your job duties/activities at work


**WORK HISTORY** Please list all previous employers before this accident. (Dates/ Employer/ Job Title/ Duties)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**SOCIAL HISTORY**

Are you? single married widowed separated divorced

Are you currently living? alone with spouse partner (name?) \_\_\_\_\_ with parents with friends other

How many children do you have (names? ages?) \_\_\_\_\_

Years married/ in long-term relationship \_\_\_\_\_ Times Married \_\_\_\_\_ Times Divorced \_\_\_\_\_

**Education.** How many years of schooling have you had? \_\_\_\_\_

Please list any degrees which you have: BA BS MBA JD MD RN PhD Other \_\_\_\_\_

- partial college training  partial high school (10th grade through partial 12th)
- high school graduate  partial junior high school (7th grade through 9th)
- GED or trade-technical school graduate  elementary school (6th grade or less)

Do you exercise? NO YES If yes \_\_\_\_\_ average min/day, \_\_\_\_\_ times/week

Describe your exercises and frequency \_\_\_\_\_

If no, why not? \_\_\_\_\_

Do you have hobbies? NO YES Please describe your hobbies and frequency: \_\_\_\_\_

**SUBSTANCE USE HISTORY**

	Yes, currently	Yes, in the past	Never	Date/Time of most recent use	Method of use	How Often?	How Much?
Alcohol							
Anti-anxiety							
Cocaine							
Crystal Meth							
Heroin							
Inhalants							
LSD							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Other							

Do you use **tobacco**?    NO    YES    \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.  
 Quit smoking \_\_\_\_\_ years ago.    Used to smoke \_\_\_\_\_ packs of cigarettes per day for \_\_\_\_\_ years.

Have you ever abused **alcohol**?    NO    YES    Attended AA?    NO    YES    If yes, when? \_\_\_\_\_

Have you ever abused **drugs**?    NO    YES    Attended NA?    NO    YES    If yes, when? \_\_\_\_\_

Did you ever stop using any of the above because of dependence?    NO    YES    If yes, please list \_\_\_\_\_  
 What was your longest period of abstinence? \_\_\_\_\_

Have you ever been **arrested or convicted**?    NO    YES    **Drug-related:**    NO    YES    **DUI:**    NO    YES

**Domestic violence**    NO    YES    Other \_\_\_\_\_

Have you ever been abused?    Physically    Verbally    Emotionally    Sexually

Have you ever had psychiatric, psychological, or social work evaluations or treatments?    NO    YES

If yes, explain \_\_\_\_\_

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**THE OSWESTRY DISABILITY INDEX**

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. We realize that you may consider more than one statement in a section applicable to you but please mark the one box that most closely describes your present day situation.

<p><b>1: Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. My pain is mild to moderate. I do not need painkillers.</li> <li><input type="checkbox"/> 1. The pain is bad but I manage without taking painkillers.</li> <li><input type="checkbox"/> 2. Painkillers give complete relief from pain.</li> <li><input type="checkbox"/> 3. Painkillers give moderate relief from pain.</li> <li><input type="checkbox"/> 4. Painkillers give very little relief from pain.</li> <li><input type="checkbox"/> 5. Painkillers have no effect on the pain.</li> </ul> <p><b>2 Personal Care</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can look after myself normally without causing pain.</li> <li><input type="checkbox"/> 1. I can look after myself normally but it causes extra pain.</li> <li><input type="checkbox"/> 2. It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> 3. I need some help but manage most of my personal care.</li> <li><input type="checkbox"/> 4. I need help every day in most aspects of self-care.</li> <li><input type="checkbox"/> 5. I do not get dressed; I wash with difficulty and stay in bed.</li> </ul> <p><b>3 Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can lift heavy weights without causing extra pain.</li> <li><input type="checkbox"/> 1. I can lift heavy weights but it causes extra pain.</li> <li><input type="checkbox"/> 2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)</li> <li><input type="checkbox"/> 3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> 4. I can lift very light weights.</li> <li><input type="checkbox"/> 5. I cannot lift or carry anything at all.</li> </ul> <p><b>4 Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can walk as far as I wish.</li> <li><input type="checkbox"/> 1. Pain prevents me from walking more than 1 mile.</li> <li><input type="checkbox"/> 2. Pain prevents me from walking more than ½ mile.</li> <li><input type="checkbox"/> 3. Pain prevents me from walking more than ¼ mile.</li> <li><input type="checkbox"/> 4. I can walk only if I use a cane or crutches.</li> <li><input type="checkbox"/> 5. I am in bed or in a chair for most of every day.</li> </ul> <p><b>5. Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can sit in any chair for as long as I like.</li> <li><input type="checkbox"/> 1. I can sit in my favorite chair only, but for as long as I like.</li> <li><input type="checkbox"/> 2. Pain prevents me from sitting for more than 1 hour.</li> <li><input type="checkbox"/> 3. Pain prevents me from sitting for more than ½ hour.</li> <li><input type="checkbox"/> 4. Pain prevents me from sitting for more than 10 minutes.</li> <li><input type="checkbox"/> 5. Pain prevents me from sitting at all.</li> </ul>	<p><b>6. Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can stand as long as I want without extra pain.</li> <li><input type="checkbox"/> 1. I can stand as long as I want but it gives me extra pain.</li> <li><input type="checkbox"/> 2. Pain prevents me from standing for more than 1 hour.</li> <li><input type="checkbox"/> 3. Pain prevents me from standing for more than ½ hour.</li> <li><input type="checkbox"/> 4. Pain prevents me from standing for more than 10 min.</li> <li><input type="checkbox"/> 5. Pain prevents me from standing at all.</li> </ul> <p><b>7. Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. Pain does not prevent me from sleeping well.</li> <li><input type="checkbox"/> 1. I sleep well but only when taking medicine.</li> <li><input type="checkbox"/> 2. Even when I take medication, I sleep less than 6 hours.</li> <li><input type="checkbox"/> 3. Even when I take medication, I sleep less than 4 hours.</li> <li><input type="checkbox"/> 4. Even when I take medication, I sleep less than 2 hours.</li> <li><input type="checkbox"/> 5. Pain prevents me from sleeping at all.</li> </ul> <p><b>8. Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. My social life is normal and causes me no extra pain.</li> <li><input type="checkbox"/> 1. My social life is normal but increased the degree of pain.</li> <li><input type="checkbox"/> 2. Pain affects my social life by limiting only my more energetic interests such as dancing, sports, etc.</li> <li><input type="checkbox"/> 3. Pain has restricted my social life and I do not go out as often.</li> <li><input type="checkbox"/> 4. Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> 5. I have no social life because of pain.</li> </ul> <p><b>9. Sexual Activity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. My sexual activity is normal and causes no extra pain.</li> <li><input type="checkbox"/> 1. My sexual activity is normal but causes some extra pain.</li> <li><input type="checkbox"/> 2. My sexual activity is nearly normal but is very painful.</li> <li><input type="checkbox"/> 3. My sexual activity is severely restricted by pain.</li> <li><input type="checkbox"/> 4. My sexual activity is nearly absent because of pain.</li> <li><input type="checkbox"/> 5. Pain prevents any sexual activity at all.</li> </ul> <p><b>10. Traveling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0. I can travel anywhere without extra pain.</li> <li><input type="checkbox"/> 1. I can travel anywhere but it gives me extra pain.</li> <li><input type="checkbox"/> 2. Pain is bad but I manage journeys over 2 hours.</li> <li><input type="checkbox"/> 3. Pain restricts me to journeys of less than 1 hour.</li> <li><input type="checkbox"/> 4. Pain restricts me to necessary journeys under ½ hour.</li> <li><input type="checkbox"/> 5. Pain prevents traveling except to the doctor/hospital</li> </ul>
--	---

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Score: \_\_\_\_\_ / \_\_\_\_\_

On this questionnaire are groups of statements. Please read each group of statements carefully then pick out the statement in each group that best describes the way you have been feeling the past week including today. Circle the number next to the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<b>1</b>	0 I do not feel sad 1 I feel sad 2 I am sad all the time and I can't snap out of it. 3 I am so sad or unhappy that I can't stand it.	<b>12</b>	0 I have not lost interest in other people. 1 I am less interested in other people than I used to be. 2 I have lost most of my interest in other people. 3 I have lost all of my interest in other people.
<b>2</b>	0 I am not particularly discouraged about the future 1 I feel discouraged about the future. 2 I feel I have nothing to look forward to 3 I feel that the future is hopeless and that things cannot improve.	<b>13</b>	0 I make decisions about as well as I ever could. 1 I put off making decisions more than I used to. 2 I have greater difficulty in making decisions than before. 3 I can't make decisions at all anymore.
<b>3</b>	0 I do not feel like a failure. 1 I feel I have failed more than the average person. 2 As I look back on my life, all I can see is a lot of failures. 3 I feel I am a complete failure as a person.	<b>14</b>	0 I don't feel I look any worse than I used to. 1 I am worried that I am looking old or unattractive. 2 I feel that there are permanent changes in my appearance that make me look unattractive. 3 I believe that I look ugly.
<b>4</b>	0 I get as much satisfaction out of things as I used to 1 I don't enjoy things the way I used to. 2 I don't get real satisfaction out of anything anymore. 3 I am dissatisfied or bored with everything.	<b>15</b>	0 I can work about as well as before. 1 It takes an extra effort to get started at doing something. 2 I have to push myself very hard to do anything. 3 I can't do any work at all.
<b>5</b>	0 I don't feel particularly guilty 1 I feel guilty a good part of the time 2 I feel quite guilty most of the time 3 I feel guilty all of the time.	<b>16</b>	0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep.
<b>6</b>	0 I don't feel I am being punished 1 I feel I may be punished 2 I expect to be punished 3 I feel I am being punished	<b>17</b>	0 I don't get more tired than usual. 1 I get tired more easily than I used to. 2 I get tired for doing almost anything. 3 I am too tired to do anything.
<b>7</b>	0 I don't feel disappointed in myself 1 I am disappointed in myself 2 I am disgusted with myself. 3 I hate myself	<b>18</b>	0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore.
<b>8</b>	0 I don't feel I am any worse than anybody else. 1 I am critical of myself for my weaknesses or mistakes 2 I blame myself all the time for my faults. 3 I blame myself for everything bad that happens	<b>19</b>	0 I haven't lost much weight, if any, lately. 1 I have lost more than 5 pounds. I am purposely trying to lose weight by eating less. 2 I have lost more than 10 pounds. 3 I have lost more than 15 pounds.
<b>9</b>	0 I don't have any thoughts of killing myself 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself 3 I would kill myself if I had the chance	<b>20</b>	0 I am no more worried about my health than usual. 1 I am worried about physical problems such as aches and pains, upset stomach or constipation. 2 I am very worried about physical problems and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think about anything else.
<b>10</b>	0 I don't cry any more than usual. 1 I cry more now than I used to 2 I cry all the time now 3 I used to be able to cry but now I can't cry even though I want to.	<b>21</b>	0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
<b>11</b>	0 I am no more irritated now than I ever am. 1 I get annoyed or irritated more easily than I used to. 2 I feel irritated all the time now. 3 I don't get irritated at all by the things that used to irritate me.		

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