Periodic Outcomes Evaluation

Texas Back Institute

PAIN DIAGRAM

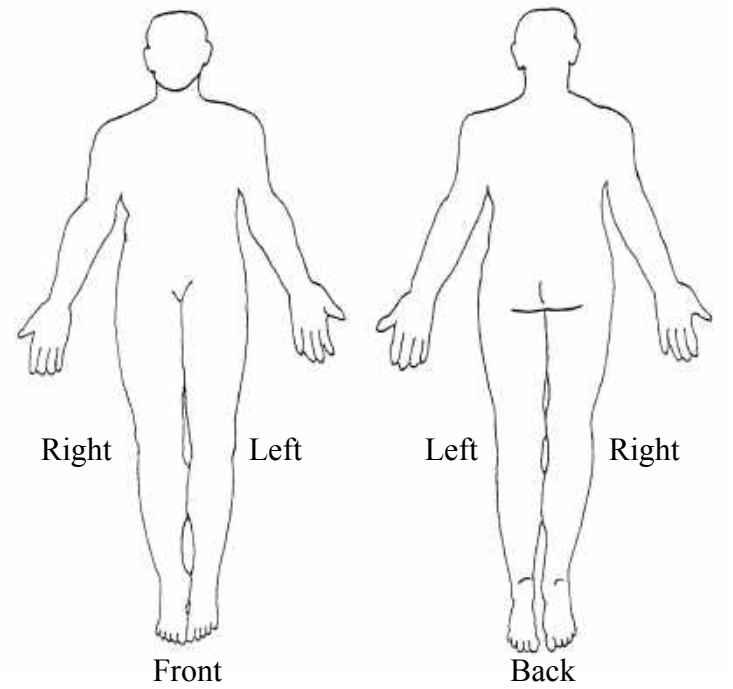
Name _____ DOB _____ Gender M / F Date _____
Please tell us which provider you are seeing today: _____

Follow Up For:

MRI /Facility:	Flare Up /Date:	RX Refill
PT /Facility:	Spine Surgery /Type:	Last Seen _____
Injection /Date:	Referral /By:	Other _____

Ache ^^^^
Numbness 0000
Pins & Needles ====
Burning xxxx
Stabbing ////

Please mark the areas where you experience the following sensations:



Medications: (circle ones to be refilled)
_____
_____
_____

New Medication:
(List all from other doctors)
_____
_____
_____

To be completed by MA:
Allergies/Reactions:
_____
_____

Height	
Weight	
Pulse	
BP	
Temp	
BMI	

Please Circle Your Answer Below

Since your last office visit are you: better worse the same?

How bad is your pain? Place an "X" (_____X_____) on each of the lines below to indicate your current pain.

How bad is your low back pain?
No pain ——————————————— Worst possible

How bad is your leg pain?
No pain ——————————————— Worst possible

How bad is your middle back pain?
No pain ——————————————— Worst possible

How bad is your neck pain?
No pain ——————————————— Worst possible

How bad is your arm pain?
No pain ——————————————— Worst possible

Please fill out these forms completely!

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.

Thank you for helping us to know you better!

Date:_____

Patient Name:_____
(please print)

Gender: Male Female

Date of Birth:_____
(month/day/year)

Current Age:_____

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

_____

_____

_____

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

I don't know how it began.
It comes and goes.
I've had it a long time. (_____years)
Injury (date of injury_____) On the job? yes no
Please explain how the injury happened.

_____

Are you currently in litigation with regards to your back pain?
yes no

Have you been laid off from your job? yes no N/A

Do you have any of the following problems?
(Please check your answer.)

Is your pain worse at night?	yes	no
Does your pain awaken you from sleep?	yes	no
Does coughing affect your pain?	yes	no
Do your legs tire/hurt if you walk too far?	yes	no

If YES, how far can you walk?
less than 1 block 1-3 blocks more than 3 blocks

Is this relieved by resting your legs?	yes	no
Is this relieved by bending forward?	yes	no

Bladder Control (urine):
No problem
Can't empty bladder
Loss of urine (accidents)

Bowel Control:
No problem
Constipation
Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	Better	Worse	No change	
Standing	Better	Worse	No change	
Walking	Better	Worse	No change	
Lying down	Better	Worse	No change	
Rising from chair	Better	Worse	No change	
Physical activity	Better	Worse	No change	
Heat	Better	Worse	No change	Don't know
Cold	Better	Worse	No change	Don't know
Massage	Better	Worse	No change	Don't know

PREVIOUS TREATMENT

We need to know about the treatments you have already received for your <u>current</u> back/neck pain. If YES, did it make your condition better or worse?

<u>Have you had</u>:

Chiropractic care	better	worse
Physical therapy	better	worse
Injections	better	worse
Psychological consultation	better	worse
Other:_____	better	worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6 mo	**< 12 mo**
X-rays		
MRI scan		
CT scan		
Myelogram		
Discogram		
EMG/NCV(nerve test)		

Have you ever had surgery <u>on your back or neck</u>?
yes no **If YES, complete the following:**

1) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain better or worse?

2) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain better or worse?

3) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain better or worse?

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check

Heart attack	Colon problems	Gout	Enlarged prostate
Heart murmur	Diabetes	Anxiety	Menstrual problems
Angina	Hepatitis	Depression	Cancer: type_____
High blood pressure	Cirrhosis	Emphysema	Osteoporosis
Stroke	Kidney stones	Tuberculosis	
Varicose veins	Kidney infection	Chronic bronchitis	Have you used :
Stomach ulcer	Degenerative arthritis	Frequent pneumonia	Immuno-suppression?
Duodenal problems	Rheumatoid arthritis	Asthma	Corticosteroids
Anemia (low blood count)	Bleeding tendency	Sexual difficulty	Other_____

List any major surgery you have had, <u>other than</u> on your back or neck.

Type of surgery	Year
1._____	_____
2._____	_____
3._____	_____

Are you <u>allergic to any medications, foods or environmental substances</u>?
yes no If YES, list the medications.
_____
_____

Do you take any medications, <u>including</u> herbal, over-the-counter, and prescription?
yes no If YES, list <u>all</u> medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY MEDICAL HISTORY

☐**I do not know the medical history of my biological parents or other family members.** (Go on to next section.)	Mother: Alive age:____ Deceased at age:__ due to_____	Father: Alive age:____ Deceased at age:__ due to_____	Number of living brothers/sisters____, Number of deceased brothers/sisters____, cause(s)_____

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply:

Stroke	Heart trouble	Kyphosis
Diabetes	Back problems	Arthritis
Lung disease	Cancer	None of these
High blood pressure	Osteoporosis	Don't know
	Scoliosis	Other_____

SOCIAL HISTORY

Marital Status
- Married
- Separated
- Divorced
- Single
- Widow/widower

Education
Check the highest level completed:
- Grammar school
- High school
- College
- Post-graduate

Smoking
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Smoker – Current Status Unknown
- ☐ Unknown If Ever Smoked

Patient Smokes: ☐ Every Day ☐ Some Days
Year Started _____
- ☐ Cigarettes Amt: _____ packs/day
- ☐ Cigars Amt: _____ # per week
- ☐ Smokless/Chewing Amt: ____ per Day
- ☐ Has had tobacco cessation counseling

Alcohol
Do you drink:
Beer: yes no Amt: ____ per day
Wine: yes no Amt: ____ glasses/day
Hard" drinks: yes no Amt: ____ day

Frequency of drinking:
never
rarely Amt: _____ drinks/day
socially
daily

Do you have a history of heavy drinking?
yes no

Effect of your back/neck pain on your lifestyle.

I describe my home setting as supportive of me during this time.	yes	no
I describe my work setting as supportive of me during this time.	yes	no
My pain has affected my interaction with my family and friends.	yes	no
The changes in my lifestyle due to my problem have been difficult for me.	yes	no

What is your ability to enjoy life?
- Excellent
- Very good
- Good
- Fair
- Poor

Please indicate your <u>current work status</u>.
- Working full time
- Working part time
- Seeking employment
- Not working by choice (retired, homemaker, student, etc.)
- Physically unable to work <u>due to</u> back/neck problem
- Physically unable to work <u>not due to</u> back/neck problem

<u>Before</u> having back or neck pain, did you normally work:
full time part time neither

What is your usual occupation?
_____

Do you like your work situation?
yes no N/A

Has your pain affected your ability to do your job or any other daily activities? yes no
If YES, please explain_____

Is there anything we have failed to ask that you believe is important for us to know?
yes no If YES, please explain: _____

REVIEW OF SYSTEMS

Do you have any of the following?

General:

Recent weight loss of more than 10 pounds?	yes	no
Recent weight gain of more than 10 pounds?	yes	no
Fever?	yes	no
Chills?	yes	no
Night sweats?	yes	no
Have you seen your primary care physician in the past year?	yes	no

Cardiac:

Chest pain	yes	no
Shortness of Breath	yes	no

Respiratory:

Wheezing	yes	no
Pneumonia	yes	no
Chronic cough	yes	no

Gastrointestinal:

Abdominal pain	yes	no
Nausea	yes	no
Vomiting	yes	no
Diarrhea	yes	no
Liver problems	yes	no

Skin:

Open sores	yes	no
New moles	yes	no
Poor healing	yes	no
Skin infection	yes	no

Hematoligic/Oncologic:

Easy bruising	yes	no
Blood thinning medications	yes	no
Blood transfusion	yes	no
Organ transplant	yes	no

Bones/Joints:

Shoulder pain	yes	no
Wrist/hand pain	yes	no
Hip pain	yes	no
Knee pain	yes	no
Lupus	yes	no
Muscle weakness	yes	no
Fibromyalgia	yes	no

Genitourinary:

Abnormal kidney function	yes	no
Pain with urination	yes	no
Frequent urinary infections	yes	no

Mental Health:

Sleep disturbances	yes	no
Feeling of hopelessness	yes	no

Nervous System:

Headaches	yes	no
Tremors	yes	no
Poor speech	yes	no
Changes in vision	yes	no

Endocrine:

Thyroid problems	yes	no

BACK PAIN QUESTIONNAIRE

If you have LOW BACK pain complete this page, if you have only neck pain, skip this page.

Please read: Could you please complete this questionnaire. It is designed to give us information on how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer **every section**. Mark **one box only** in each section that most closely describes you today.

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 is very painful.
_____ 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 everyday in most aspects of self care.
_____ I do not get dressed, 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, e.g. 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 only 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 walking more than 1 mile.
_____ Pain prevents me walking more than 1/2 mile.
_____ Pain prevents me walking more than 100 yards.
_____ I can only walking using a stick or crutches.
_____ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

_____ I can sit still in any chair as long as I like
_____ I can sit in my favorite chair as long as I like.
_____ Pain prevents me sitting more than 1 hour.
_____ Pain prevents me sitting more than 1/2 hour.
_____ Pain prevents me sitting more than 10 mins.
_____ Pain prevents me from sitting at all.

Section 6 - Standing

_____ I can stand as long as I want without extra pain.
_____ I can stand as long as I want but it gives me extra pain.
_____ Pain prevents me from standing for more than 1 hour.
_____ Pain prevents me from standing more than 1/2 an hour.
_____ Pain prevents me from standing for more than 10 mins.
_____ Pain prevents me from standing at all.

Section 7 - Sleeping

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

Section 8 - Sex Life (if applicable)

_____ My sex life is normal and causes no extra pain.
_____ My sex life is normal but causes some extra pain.
_____ My sex life is nearly 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

_____ My social life is normal and causes me no extra pain.
_____ My social life is normal but increases the degree of pain.
_____ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
_____ 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 pain.

Section 10 - Traveling

_____ I can travel anywhere without extra pain.
_____ I can travel anywhere but is gives me extra pain.
_____ Pain is bad but I can manage journeys over two hours.
_____ Pain restricts me to journeys of less than one hour.
_____ Pain restricts me to short necessary journeys under 30 mins.
_____ Pain prevents me from traveling except to receive treatment.

NECK PAIN QUESTIONNAIRE

If you have NECK pain complete this page, if you have only low back pain, skip this page.

Please read: This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize you may consider that two of the statements in any one section relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

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 everyday in most aspects of self care.
___ I do not get dressed, 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 with moderate pain in my neck.
___ I cannot read as much as I want because of moderate pain in my neck.
___ I cannot read as much as I want because of severe pain in my neck.
___ I cannot read at all.

Section 5 - Headaches

___ I have no headache 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.

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 of my usual work, but no more.
___ I cannot do my usual work.
___ I can hardly do any work at all.
___ I cannot do any work at all.

Section 8 - Driving

___ I can drive my car without any neck 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 cannot 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 cannot drive my car at all.

Section 9 - Sleeping

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

Section 10 - Recreation

___ I am able to engage in all of my recreational activities with no neck pain at all.
___ I am able to engage in all of my recreational activities with some pain in my neck.
___ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
___ I am able to engage in a few of my usual recreational activities because of pain in my neck.
___ I can hardly do any recreational activities because of pain in my neck.
___ I cannot do any recreational activities at all.

Patient Questionnaire

Instructions: This survey asks for your views about your health. The information will help keep track of how well you are able to do your usual activities.
Please answer each question by marking **one box**. If you are unsure about how to answer please give the best answer you can.

In general would you say your health is ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

The following items are about activities that you might do during a typical day. Does **your health <u>now</u> limit** you in these activities? If so, how much?

(Fill in **one circle on each line**)	Yes limited a lot	Yes limited a little	Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	○	○	○
Climbing several flights of stairs?	○	○	○

During the **<u>past 4 weeks</u>**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

Accomplished less than you would like.	○ Yes	○ No
Were limited in the kind of work or other activities.	○ Yes	○ No

During the **<u>past 4 weeks</u>**, 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)?

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

During the **<u>past 4 weeks</u>** how much did **pain** interfere with your normal work (including work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with you during the **<u>past 4 weeks</u>**. 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 **<u>past 4 weeks</u>**:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Have you felt calm and peaceful?	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○

During the **<u>past 4 weeks</u>**, how much of the time has your **physical health 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