Name:
DOB:
Age:
Chart:

ADVANCED
Center for Orthopedics
and Plastic Surgery

Date:

Primary Doctor: _____ Preferred Pharmacy: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Dominant Hand: Right_____ Left_____

What are you seeing us for? _____ When did it start? _____

Is this an injury related to a (Circle one): Work / Military / Auto accident? Injury date, if applicable _____

Pain worse with ☐ Sneezing ☐ Coughing ☐ Standing _____ minutes ☐ Walking distance_____

Do your legs feel ☐ Tired ☐ Weak ☐ Heavy

Describe the pain ☐ Sharp, knife-like ☐ Shock ☐ Burning ☐ Dull Ache ☐ Numb/tingling

Rate your pain between 1 and 10 (10 being the worst)	Back	Leg	Neck	Arms
Pain is usually (1-10)				
At its worst (1-10)				

Does this pain ☐ Keep you awake at night ☐ Improve with sitting ☐ Improved with leaning forward supported (shopping cart)

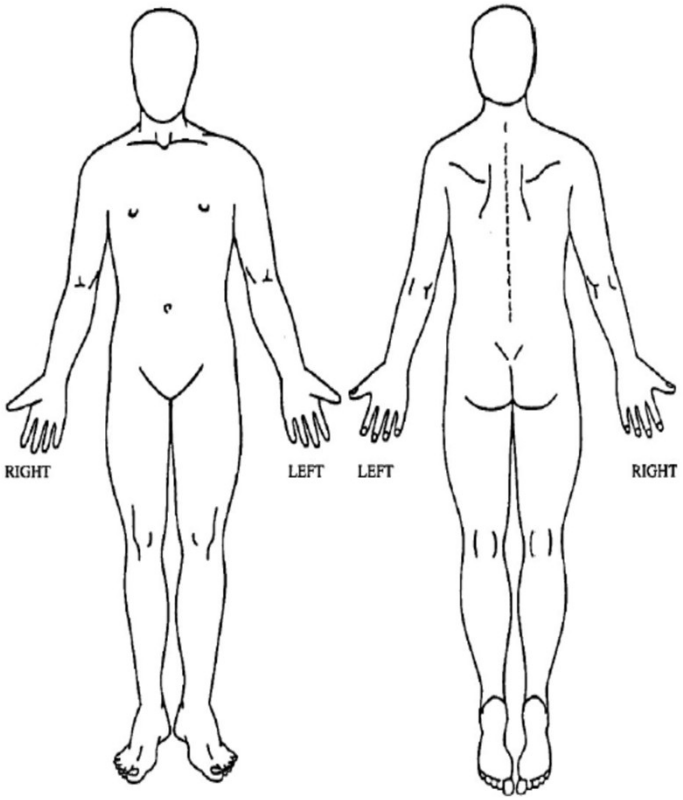
Have you noticed: ☐ Clumsy feeling legs ☐ Clumsy hands ☐ Dropping items ☐ Bladder dysfunction

Have you had any of the following treatments

☐ Tens ☐ Spine Injections ☐ Neck/Back Physical Therapy ☐ NSAIDS ☐ Tylenol

☐ Acupuncture ☐ Chiropractic Treatment ☐ Traction ☐ Spine Surgery: _____

Nicotine use? ☐ Chew ☐ Cigarettes ☐ Vape ☐ Other_____ Recreational drug use?_____



USING DIAGRAM TO THE LEFT, DESCRIBE YOUR PAIN NOW

1. Mark all the areas where sensation is felt on your body using the symbols to the right.
2. Shade all affected areas of radiation.
3. Draw in your face.
4. With an X, mark where your pain is worse now.

v v v ACHING	**x x x BURNING**
= = = NUMBING	**/ / / STABBING**
o o o PINS & NEEDLES	

MARK ON THIS LINE HOW BAD YOUR PAIN IS NOW

NO PAIN (0) _____ **(10) WORSE PAIN**

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Past Medical History / Conditions _____

_____

Past Surgeries (ALL) _____

_____

Allergies _____

Home Medication List _____

_____

Family History: ☐ Cancer ☐ Heart Attack ☐ Scoliosis ☐ High Blood Pressure ☐ Diabetes

Social History: Occupation/Retired Occupation: _____ Date Retired: _____

Marital Status ☐ M ☐ S ☐ D ☐ W Number of children_____ Alcohol per week _____

Do you have any of the following:

☐ Decreased Hearing	☐ Chest Pain	☐ Hemorrhoids	☐ Stroke
☐ Ringing in Ears	☐ High Blood Pressure	☐ Jaundice / Hepatitis	☐ Psoriasis / Eczema
☐ Ear Infections - Frequent	☐ Heart Murmur	☐ Urinary Infections - Frequent	☐ Depression
☐ Dizzy Spells	☐ Palpitations	☐ Kidney Stones / Disease	☐ Memory Loss
☐ Failing Vision	☐ Irregular Pulse	☐ Venereal / Sexually Transmitted Disease	
☐ Double or Blurred Vision	☐ Heart Attack	☐ History of Lyme's Disease	☐ Phobias
☐ Nose Bleeds - Frequent	☐ Fainting Spells	☐ Chronic Fatigue	☐ Mental Illness
☐ Sinus Trouble	☐ Swollen Ankles	☐ Weight Loss - Recent	☐ Headaches - Frequent
☐ Sore Throat - Frequent	☐ Leg Pain When Walking	☐ Anemia	☐ Tuberculosis
☐ Pneumonia / Pleurisy	☐ Varicose Veins / Phlebitis	☐ Bleed Easily	☐ Glaucoma
☐ Bronchitis / Chronic Cough	☐ Loss of Appetite - Recent	☐ Cancer	☐ Slow Healer
☐ Asthma / Wheezing	☐ Indigestion or Heartburn	☐ Diabetes	
☐ Short of Breath	☐ Bloody or Tarry Stools	☐ Convulsions	

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OSWESTRY BACK DISABILITY INDEX

Patient Name _____ DOB _____ Date _____

Visit Type: ☐ preop ☐ 6 weeks ☐ 3 months ☐ 6 months ☐ 12 months ☐ 24 months ☐ other / annual

Instructions: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark the **ONE** answer that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please mark the one which most closely describes your problem.

Section 1 - Pain Intensity
- ☐ 0 I have no pain at the moment
- ☐ 1 The pain is very mild at the moment
- ☐ 2 The pain is moderate at the moment
- ☐ 3 The pain is fairly severe at the moment
- ☐ 4 The pain is very severe at the moment
- ☐ 5 The pain is the worst imaginable at the moment

Section 2 - Personal Care
- ☐ 0 I can look after myself normally without causing extra pain
- ☐ 1 I can look after myself normally, but it causes extra pain
- ☐ 2 It is painful to look after myself, and I am slow and careful
- ☐ 3 I need some help but manage most of my personal care
- ☐ 4 I need help every day in most aspects of self care
- ☐ 5 I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
- ☐ 0 I can lift heavy weights without causing extra pain
- ☐ 1 I can lift heavy weights, but it gives me extra pain
- ☐ 2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table)
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ 4 I can lift only very light weights
- ☐ 5 I cannot lift or carry anything at all

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

Section 5 – Sitting
- ☐ 0 I can sit in a chair as long as I like
- ☐ 1 I can only sit in my favorite chair as long as I like
- ☐ 2 Pain prevents me from sitting more than 1 hour
- ☐ 3 Pain prevents me from sitting more than 30 minutes
- ☐ 4 Pain prevents me from sitting more than 10 minutes
- ☐ 5 Pain prevents me from sitting at all

Section 6 – Standing
- ☐ 0 I can stand as long as I want without extra pain
- ☐ 1 I can stand as long as I want but it gives me extra pain
- ☐ 2 Pain prevents me from standing more than 1 hour
- ☐ 3 Pain prevents me from standing more than 30 minutes
- ☐ 4 Pain prevents me from standing more than 10 minutes
- ☐ 5 Pain prevents me from standing at all

Section 7 – Sleeping
- ☐ 0 Pain does not prevent me from sleeping well
- ☐ 1 I sleep well only by using pain medication
- ☐ 2 Even when I take pain medication I have less than 6 hours sleep
- ☐ 3 Even when I take pain medication I have less than 4 hours sleep
- ☐ 4 Even when I take pain medication I have less than 2 hours sleep
- ☐ 5 Pain prevents me from sleeping at all

Section 8 – Sex Life (if applicable)
- ☐ 0 My sex life is normal and causes no extra pain
- ☐ 1 My sex life is normal but it causes extra pain
- ☐ 2 My sex life is nearly normal but is very painful
- ☐ 3 My sex life is severely restricted because of pain
- ☐ 4 My sex life is nearly absent because of pain
- ☐ 5 Pain prevents any sex life at all

Section 9 – Social Life
- ☐ 0 My social life is normal and gives me no extra pain
- ☐ 1 My social life is normal but increases the degree of pain
- ☐ 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ☐ 3 Pain has restricted my social life and I do not go out as often
- ☐ 4 Pain has restricted my social life to my home
- ☐ 5 I have no social life because of pain

Section 10 – Traveling
- ☐ 0 I can travel anywhere without extra pain
- ☐ 1 I can travel anywhere but it gives me extra pain
- ☐ 2 The pain is bad but I manage journeys over 2 hours
- ☐ 3 Pain restricts me to journeys of less than 1 hour
- ☐ 4 Pain restricts me to short necessary journeys under 30 minutes
- ☐ 5 Pain prevents me from traveling except to the doctor or hospital