

1. What are your goals for this visit?

2. What are your questions/concerns for this visit?

3. What new treatments or significant events have occurred since your last office visit?

4. Which of the following activities are part of your regular and consistent exercise program?

☐ Physical Therapy ____ times per week

☐ Stretching ____ times per week

☐ Weight Lifting ____ times per week

☐ Range of Motion (Flexibility) ____ times per week

☐ Core Strengthening (Stability) ____ times per week

☐ Aerobic Exercises (Cardio) ____ times per week

☐ Other: _____

5. What activities have you been able to resume since your last office visit?

6. Since your last office visit, have you been admitted to the hospital or had any operations?

DD/MM/YYYY

☐ No ☐ Yes: Please provide a brief description including the date of the event.

☐ Pre-op Assessment: Enroll this patient into surgical registry

Registry ID:





Last Name

First Name

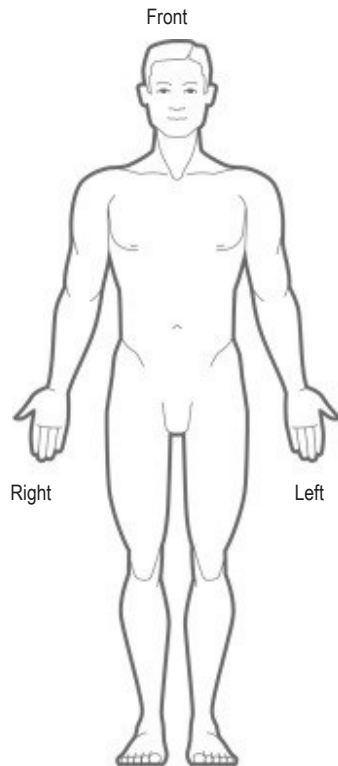
MI

Last 4 of Social Security

Date of Birth (MM/DD/YYYY)

☐ Male

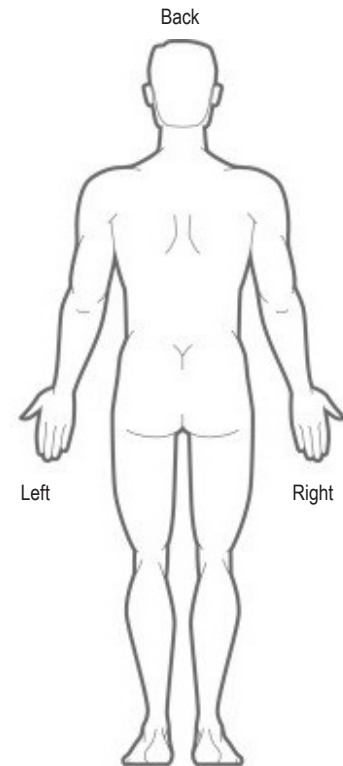
☐ Female



Where is your pain?
Use the body diagram to show
where you feel the following
sensations.

If you are completing this online,
use the add text tool.

Ache AAA
Numbness 000
Burning XXX
Stabbing ///
Pins and Needles ---



On a scale from 0 to 10, with 0 being none and 10 being unbearable, please mark your level of pain/discomfort for each of these areas by placing an "x" in the box of the best answer.

(Mark only one box for each scale)

____ Neck Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

____ Right Arm Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

____ Left Arm Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

____ Back Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

____ Right Leg Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10

____ Left Leg Pain

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	1	2	3	4	5	6	7	8	9	10





Last Name

First Name

MI

Last 4 of Social Security

Date of Birth (MM/DD/YYYY)

☐ Male

☐ Female

If you have **low back pain**, please answer the following questions by placing an "x" in the box of the best answer.
(Mark only one box for each question)

___ 01. 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.

___ 02. Personal Care (e.g. washing, dressing, etc.)

- ☐ I can look after myself normally without it 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.

___ 03. 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. (I.e. 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.

___ 04. 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 stick or crutches.
- ☐ I am in bed most of the time, and have to crawl to the toilet.

___ 05. Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than thirty minutes.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

___ 06. Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives extra pain.
- ☐ Pain prevents me from standing more than one hour.
- ☐ Pain prevents me from standing more than thirty minutes.
- ☐ Pain prevents me from standing more than ten minutes.
- ☐ Pain prevents me from standing at all.

___ 07. Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than six hours sleep.
- ☐ Even when I take tablets, I have less than four hours sleep.
- ☐ Even when I take tablets, I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

___ 08. Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (E.g. lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

___ 09. Social Life

- ☐ My social life is normal, and gives 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 energetic interests. (E.g. dancing, etc.).
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

___ 10. Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives extra pain.
- ☐ Pain is bad, but I manage journeys over two hours.
- ☐ Pain restricts me to journeys less than one hour.
- ☐ Pain restricts me to short journeys under thirty minutes.
- ☐ Pain prevents me from traveling, except to the doctor or hospital.





Last Name

First Name

MI

Last 4 of Social Security

Date of Birth (MM/DD/YYYY)

☐ Male

☐ Female

If you have **neck pain**, please answer the following questions by placing an "x" in the box of the best answer.
(Mark only one box for each question)

— 01. 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.

— 02. Personal Care (e.g. washing, dressing, etc.)

- ☐ I can look after myself normally without it 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.

— 03. 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. (I.e. 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.

— 04. 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 cannot read at all because of pain in my neck.

— 05. Headaches

- ☐ 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.

— 06. Concentration

- ☐ I can concentrate fully when I want to, without 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 concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want to.
- ☐ I cannot concentrate at all.

— 07. 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 can't do any work at all.

— 08. 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 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.

— 09. 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).

— 10. Recreation

- ☐ I am able to engage in all of my recreational activities with no 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 recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my 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.





Last Name

First Name

MI

Last 4 of Social Security

Date of Birth (MM/DD/YYYY)

☐ Male

☐ Female

Please answer the following questions by placing an "x"
in the box of the best answer.
(Mark only one box for each question)

01. Mobility (mark only one box)

- ☐ I have no problems walking about.
☐ I have some problems walking about.
☐ I am confined to bed.

02. Self-Care (mark only one box)

- ☐ I have no problems with self-care.
☐ I have some problems washing or dressing myself.
☐ I am not able to wash or dress myself.

03. Usual activities (work, housework, family or leisure activities) (mark only one box)

- ☐ I have no problems with performing my usual activities.
☐ I have some problems with performing my usual activities.
☐ I am unable to perform my usual activities.

04. Pain/Discomfort (mark only one box)

- ☐ I have no pain or discomfort.
☐ I have moderate pain or discomfort.
☐ I have extreme pain or discomfort.

05. Anxiety/Depression (mark only one box)

- ☐ I am not anxious or depressed.
☐ I am moderately anxious or depressed.
☐ I am extremely anxious or depressed.

On a scale of 0 to 100,
with 0 being your worst
imaginable health state
and 100 being your
best imaginable health
state, please indicate
your current health state
by placing an x on a point
on the scale (similar to a
thermometer) to the right.

