

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

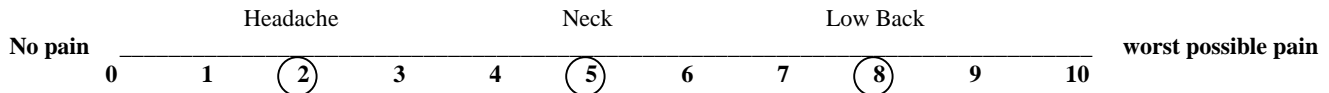
Date _____

Please read carefully:

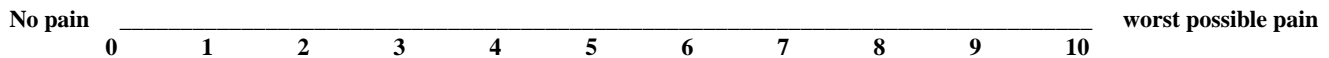
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

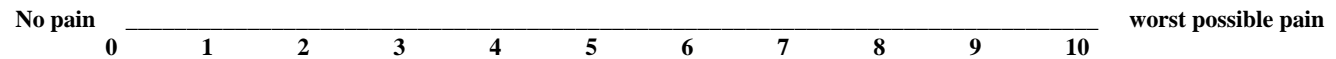
Example:



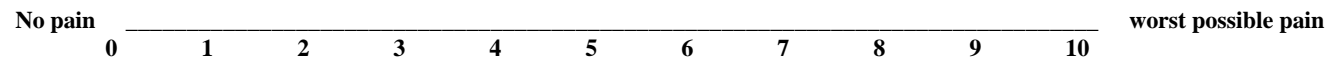
1 – What is your pain RIGHT NOW?



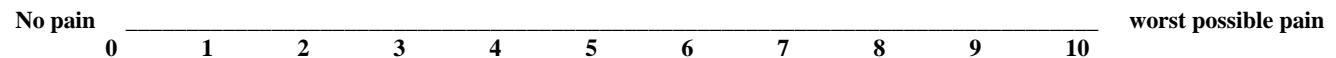
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



Other Comments: _____

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____

Score: Total all scores; divide by number of regions x 10 = _____ (< 50 LI / > 50 HI)

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, w/ permission from Elsevier Science.

ROLAND MORRIS QUESTIONNAIRE

When your back hurts you may find it difficult to perform many activities throughout the day. Statements listed below have been used by people to describe those times when they are experiencing back pain. As you read them, some may stand out because they describe your pain *today*.

Therefore, please check the box that best describes your pain today. If the sentence does not fit, then just leave it blank and move on to the next one.

- I stay at home most of the time because of my back.
- I change positions frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to walk upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of my chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back pain.
- I have trouble putting on my socks or stockings because of my back .
- I only walk short distances because of my back pain.
- I don't sleep well because of my back.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad –tempered with people than usual.
- Because of my back pain, I walk upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Additional Comments:

Patient Name _____ Patient Signature _____

Examiner _____ Date _____ SCORE _____ (24)

NECK BOURNEMOUTH QUESTIONNAIRE

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Patient Name _____ Patient Signature _____

Examiner _____ Date _____ Score _____ (70)

RE-EVALUATION ACTIVITIES OF DAILY LIVING (ADL)

From the initial ADL's, please write only 3 activities that you were able to perform before the accident.

Must give quantity (time & amount).

For example: I have difficulty lifting more than 20 lbs because of the pain in my back.

1. _____

2. _____

3. _____

PATIENT (PRINT AND SIGN): _____ DATE: _____

INITIAL ACTIVITIES OF DAILY LIVING (ADL)

Please circle or fill in all that apply to you. (cause increase symptoms due to injury)

- | | | |
|---|--|--------------|
| 1. Difficulty sitting more than: | 10 mins, 15 mins, 25 mins, 40 mins, 60 mins. | _____mins |
| 2. Difficulty lifting more than: | 10 lbs, 15 lbs, 20 lbs, 35 lbs, 50 lbs. | _____lbs |
| 3. Difficulty house cleaning more than: | 5 mins, 10 mins, 15 mins, 20 mins, 30 mins. | _____mins |
| 4. Difficulty standing more than: | 10 mins, 20 mins, 30 mins, 45 mins, 60 mins. | _____mins |
| 5. Difficulty reading more than: | 5 mins, 10 mins, 20 mins, 35 mins, 45 mins. | _____mins |
| 6. Difficulty walking more than: | 5 mins, 10 mins, 20 mins, 35 mins, 45 mins. | _____mins |
| 7. Difficulty exercising more than: | 5 mins, 10 mins, 20 mins, 30 mins, 40 mins. | _____mins |
| 8. Difficulty sleeping for more than: | 6 hrs, 5 hrs, 4 hrs, 3 hrs, 2 hrs. | _____hours |
| 9. Difficulty writing more than: | 5 mins, 10 mins, 15 mins, 20 mins, 30 mins. | _____mins |
| 10. Difficulty typing more than: | 5 mins, 10 mins, 15 mins, 20 mins, 30 mins. | _____mins |
| 11. Difficulty playing golf more than: | 2 holes, 4 holes, 6 holes, 10 holes, 14 holes. | _____holes |
| 12. Difficulty holding objects more than: | 3 secs, 5 secs, 15 secs, 30 secs, 45 secs. | _____seconds |
| 13. Difficulty walking up more than: | 5 steps, 10 steps, 15 steps, 20 steps, 30 steps. | _____steps |
| 14. Difficulty grasping more than: | 1 min, 2 mins, 3 mins, 4 mins, 5 mins. | _____mins |
| 15. Difficulty talking on the phone more than: | 2mins, 5 mins, 10 mins, 20 mins, 30 mins. | _____mins |
| 16. Difficulty cooking for self and family more than: | 5 mins, 10 mins, 15 mins, 20 mins, 30 mins. | _____mins |
| 17. Difficulty with sexual performance more than: | 5 mins, 10 mins, 15 mins, 20 mins, 25 mins. | _____mins |
| 18. Difficulty turning neck while driving more than: | 5 mins, 10 mins, 20 mins, 30 mins, 40 mins. | _____mins |
| 19. Difficulty playing with the children more than: | 5 mins, 10 mins, 15 mins, 25 mins, 35 mins. | _____mins |
| 20. Difficulty performing job duties more than: | 10 mins, 20 mins, 40 mins, 60 mins, 90 mins. | _____mins |



Please write any additional activities that affect you; must also give the time or amount.

PATIENT (PRINT AND SIGN): _____

DATE: _____

PATIENT SURVEY

In order to provide better patient care, we have a few questions that will just a few minutes to complete. Please mark the circle that best corresponds to your feelings. We certainly appreciate your feedback.


STRONGLY DISAGREE
→
STRONGLY AGREE


1. WHEN I CALLED THE OFFICE THE PHONE WAS ANSWERED PROMPTLY AND COURTEOUSLY...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. OUR STAFF SCHEDULED MY APPOINTMENTS AT CONVENIENT TIMES...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. WHEN ARRIVING I WAS PROMPTLY CHECKED-IN AND TREATED...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. OUR STAFF TREATED ME RESPECTFULLY AND COURTEOUSLY...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. THE DOCTOR AND STAFF WERE GENUINELY CONCERNED THROUGHOUT MY TREATMENT AND GAVE ME HELPFUL ADVICE...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. THE DOCTOR TOOK TIME ANSWERING MY QUESTIONS AND CLEARLY EXPLAINED MY DIAGNOSIS AND TREATMENT PLAN...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. OVERALL OFFICE APPEARANCE WAS NEAT AND PROFESSIONAL...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. OUR STAFF CLEARLY EXPLAINED MY FINANCIAL OBLIGATIONS...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. VISITING THE OFFICE EXCEEDED MY EXPECTATIONS...

1	2	3	4	5	6
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Additional Patient Comments:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ SCORE _____ (54)