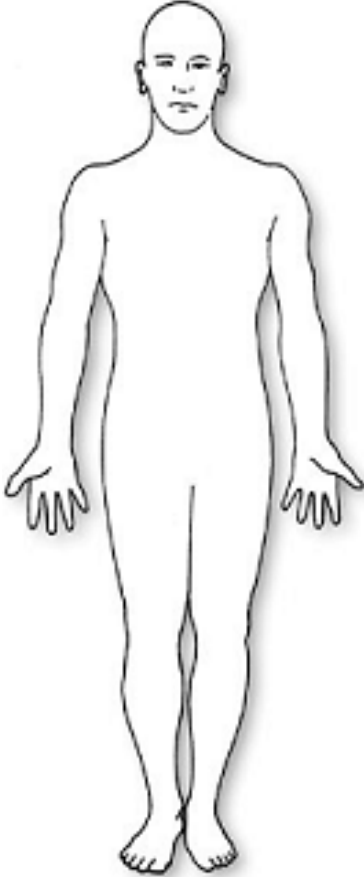


Date: _____


Patient: _____

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Mark how bad it is on the pain scale in the section below:

FRONT



BACK



●●●● Numbness
○○○○○ Pins & Needles
××××× Burning Pain
//////// Stabbing Pain
vvvvvv Aching Pain

Use the following scale to indicate the severity of your pain:

None		Annoying		Uncomfortable		Dreadful		Horrible		Agonizing	
0	1	2	3	4	5	6	7	8	9	10	
No pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain	

HISTORY OF PRESENT ILLNESS

1. Please indicate how long you have had your present pain (circle one):

A. less than a month	D. 6 months to a year
B. 1 to 3 months	E. more than a year
C. 3 to 6 months	

2. When did your present pain begin? (date) _____ / _____ / _____

3. Please indicate how your present pain began (circle one):

A. occurred during an athletic activity	E. occurred while lifting
B. occurred as a result of an auto accident	F. occurred while working
C. occurred while sitting	G. unknown
D. occurred while bending	

4. Is the injury work related? (check one)

Yes _____	No _____	Unsure _____
-----------	----------	--------------

5. Is your current injury filed as a workers comp claim?

Yes _____	No _____	Unsure _____
-----------	----------	--------------

6. Have you ever had a workers comp claim in the past?

Yes _____	No _____	Unsure _____
-----------	----------	--------------

7. Using the following list of treatments, please indicate the effect of those that have been used in an attempt to heal your present injury:

	Helpful	Not Helpful	Duration of Effect
Back School			
Hot Packs			
Ice			
TENS Unit			
Traction			
Arching Exercises			
Sit Up Exercises			
Acupuncture			
Chiropractor			
Epidural Block			
Facet Block			
Ultrasound			
Physical Therapy			
Other			

8. Please indicate with a check mark if you have had any of the following studies:

	Yes	No		Yes	No
Regular x-ray of spine	<input type="checkbox"/>	<input type="checkbox"/>	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>

9. Have you had spinal surgery in the past? Yes _____ No _____
 If so, how many? _____

10. If you answered "Yes" to question 7, please complete the following:

A. What type of surgery was performed (please check)?
 Unknown _____ Disc Removal _____ Fusion _____

B. What was the date of your most recent surgery? _____ / _____ / _____

C. Did you improve from your surgical procedure(s)?
 Most recent surgery? Yes _____ No _____

11. Please check any of the problems which you have had in the past six months:

Chest pain, tightness	_____	Persistent/recurring belly pain	_____
Palpitations	_____	Uncontrolled loss of stool	_____
Shortness of breath with normal activities	_____	Diarrhea	_____
Loss of bladder control	_____	Blood in stool	_____
Fevers, chills or sweats	_____	Constipation	_____
Yellow jaundice	_____	Pain with bowel movement	_____

Family History of (check all that apply):

Arthritis	_____	Migraine headaches	_____
Back pain	_____	Tuberculosis	_____
Neck pain	_____		

12. Are you a cigarette smoker? Yes _____ No _____

If you answered "Yes" how much do you smoke per day?

Less than 1/2 pack per day	_____	1 pack per day	_____
1/2 pack per day (10 cigarettes)	_____	More than 1 pack per day	_____
3/4 pack per day (15 cigarettes)	_____		

13. Do you drink alcoholic beverages?

None	_____	3 to 5 drinks per day	_____
1 to 2 drinks per week	_____	more than 5 drinks per day	_____
1 to 2 drinks per day	_____		

14. List all previous surgeries, excluding the back or neck surgeries you have already discussed:

15. List all other major illnesses:

16. Are you under a doctor's care for any medical condition? Yes_____ No_____

17. Are you (check one):

Unemployed_____ Employed_____ Student_____ Retired_____

If you answered "Unemployed" or "Employed", please answer the following questions:

A. How long have you been off work this year (circle one):

- | | |
|-------------------------|------------------------------------|
| 1. No time | 4. About 1 to 6 months |
| 2. About 1 week | 5. About 6 months to a year |
| 3. About 1 month | |

B. Are you presently working? Yes_____ No_____

If you answered "No", please complete the following:

- 1. What was the date last worked: _____/_____/_____**
- 2. Is your job still available? Yes_____ No_____**

C. Was your reason for leaving work due to a back or neck problem: Yes_____ No_____

18. Are you (circle one):

- | | |
|--------------------|---------------------|
| 1. Single | 4. Separated |
| 2. Married | 5. Widowed |
| 3. Divorced | |

19. Number of children, if any: _____

20. Current source of income (circle all that apply):

- | | |
|--------------------|-------------------------|
| 1. Spouse | 5. Unemployment |
| 2. Employer | 6. Workers compensation |
| 3. Social security | 7. Other funds |
| 4. Disability | 8. Private earnings |

CURRENT PAIN PROFILE

21. How would you compare your pain ratio (check one)?

100% back pain to 0% leg pain	100% back pain to 0% neck pain	100% neck pain to 0% arm pain
75% back pain to 25% leg pain	75% back pain to 25% neck pain	75% neck pain to 25% arm pain
50% back pain to 50% leg pain	50% back pain to 50% neck pain	50% neck pain to 50% arm pain
25% back pain to 75% leg pain	25% back pain to 75% neck pain	25% neck pain to 75% arm pain
0% back pain to 100% leg pain	0% back pain to 100% neck pain	0% neck pain to 100% arm pain

22. Which of the following activities change the nature of your pain (check all that apply):

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Rising from sitting			
Leaning forward (brushing teeth)			
Walking			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Bending forward			

Now go back and circle the boxes to indicate the most aggravating activity and the most relieving activity.

23. Please answer the following questions:

- | | | |
|--------------------------|-------|----------------------------|
| A. Unable to tolerate | _____ | A. How long can you sit? |
| B. About 15 minutes only | _____ | B. How long can you stand? |
| C. About 30 minutes only | _____ | C. How long can you walk? |
| D. About 45 minutes | | |
| E. About 1 hour | | |
| F. Indefinite period | | |

MEDICATIONS

24. Please list any medication you take at the present time:

Now go back and put a check mark next to those medications, which help relieve your pain.

OSWESTERY FUNCTION TEST

Complete this form only if you have back or leg problems (Pages 6-8).

25. Please answer the following questions by placing the number of the most applicable on the blank lines:

A. How long have you had back pain?

_____ About 1 week
 _____ About 1 month
 _____ About 3 months
 _____ About 6 months
 _____ About 1 year

B. How long have you had leg pain?

_____ About 1 week
 _____ About 1 month
 _____ About 3 months
 _____ About 6 months
 _____ About 1 year

26. Please check the one answer in each section that best applies to your condition.

PAIN INTENSITY

	I can tolerate my pain without having to use painkillers.
	My pain is bad, but I can manage without taking painkillers.
	Painkillers give me complete relief from my pain.
	Painkillers give me moderate relief from my pain.
	Painkillers give me very little relief from my pain.
	Painkillers have no effect on my pain and I do not use them.

PERSONAL CARE (WASHING, DRESSING, ETC)

	I can look after myself normally without causing extra pain.
	I can look after myself normally, but causes extra pain.
	It is painful to look after myself and I am slow and careful.
	I need some help but I manage my personal care.
	I need every day in most aspects of self-care.
	I do not get dressed, wash with difficulty, and stay in bed.

LIFTING

	I can lift heavy objects without extra pain.
	I can lift heavy objects, but it gives me extra pain.
	Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned.
	Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
	I can only lift very light objects.
	I cannot lift or carry anything at all.

WALKING

	Pain does not prevent me from walking any distance.
	Pain prevents me from walking more than a mile.
	Pain prevents me from walking more than ½ mile.
	Pain prevents me from walking more than ¼ mile.
	I can only walk using a cane or crutches.
	I am in bed most of the time and have to crawl to the toilet.

SITTING

	I can sit in my 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 1 hour.
	Pain prevents me from sitting more than ½ hour.
	Pain prevents me from sitting more than 10 minutes.
	Pain prevents me from sitting at all.

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 more than 1 hour.
	Pain prevents me from standing more than ½ hour.
	Pain prevents me from standing more than 10 minutes.
	Pain prevents me from standing at all.

SLEEPING

	Pain does not prevent me from sleeping well.
	I can sleep well only by taking medication for sleep.
	Even when I take medication I have less than 6 hours sleep.
	Even when I take medication I have less than 4 hours sleep.
	Even when I take medication I have less than 2 hours sleep.
	Pain prevents me from sleeping at all.

SEX LIFE

	My sex life is normal and causes me no extra pain.
	My sex life is normal and causes me 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.

SOCIAL LIFE

	My life 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 like dancing, 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.

TRAVEL

	I can travel anywhere without pain.
	I can travel anywhere but it gives me extra pain.
	Pain is bad, but I manage journeys over 2 hours.
	Pain restricts me to journeys of less than 1 hour.
	Pain restricts me to short necessary journeys under 1/2 hour.
	Pain prevents me from traveling except to the doctor or hospital.

Neck Disability Index. Complete this form only if you have neck or arm problems. This questionnaire has been designed to give your doctor information as to how your pain has affected you in your everyday life activities. Please answer each section; circle one letter, which best describes your status today.

Section 1-Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

Section 2-Personal Care (Washing, dressing, etc.)

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally but it causes me extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some extra help but manage most of my personal care.
- E. I need help everyday on most aspects of self-care.
- F. I do not get dressed, wash with difficulty and stay in bed.

Section 3-Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can only lift very lightweight.
- F. I cannot lift or carry anything at all.

Section 4-Reading

- A. I can read as much as I want to with no pain in

Section 6-Concentration

- A. I concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I cannot concentrate at all.

Section 7-Work

- A. I can do as much as I want to.
- B. I can do my usual work but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do my work at all.
- F. I cannot do any work at all.

Section 8-Driving

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want to with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

Section 9-Sleeping

- A. I have no trouble sleeping at all.
- B. My sleep is slightly disturbed (less than 1 hour sleep loss).
- C. My sleep is mildly disturbed (1-2 hour sleep

- my neck.
- B. I can read as much as I want to with a slight pain in my neck.
- C. I can read as much as I want to with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I can hardly read at all because of severe pain in my neck.
- F. I cannot read at all.

Section 5-Headache

- A. I have no headaches at all.
- B. I have slight headaches, which come infrequently.
- C. I have moderate headaches, which come infrequently.
- D. I have moderate headaches, which come frequently.
- E. I have severe headaches, which come frequently
- F. I have headaches almost all the time.

- loss).
- D. My sleep is moderately disturbed (2-3 hour sleep loss).
- E. My sleep is greatly disturbed (3-5 hour sleep loss).
- F. My sleep is greatly disturbed (3-5 hour sleep loss).

Section 10-Recreation

- A. I am able to engage in all my recreational activities with no neck pain at all.
- B. I am able to engage in all my recreational activities with some pain in my neck.
- C. I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- D. I am able to engage in few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of my neck.
- F. I cannot do any recreational activities.

ACTIVITIES OF DAILY LIVING COMMONLY MEASURED IN ACTIVITIES OF DAILY LIVING (ADL)*

APPLICANT HAS DIFFICULTY WITH: MARK WITH AN "X" BELOW AND EXPLAIN WHERE INDICATED						
	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
1	SELF CARE, PERSONAL HYGIENE: Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating	Shower				
		Bath				
		Wash/Dry Body				
		Wash and Dry Face				
		Turn On/Off Faucets				
		Brush Teeth				
		Get On/Off Toilet				
		Comb/Brush Hair				
		Dress Self				
		Put On/Off Shoes/Socks				
		Open a Carton of Milk				
		Open a Jar				
		Lift Glass/Cup to Mouth				
		Make a Meal				
		Lift Fork/Spoon to Mouth				
Describe other: bladder and bowel function difficulties, incontinence, retention, constipation?						

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
2	PHYSICAL ACTIVITY: Standing, sitting, reclining, walking, climbing stairs	Stand				
		Sit				
		Recline				
		Rise From a Chair				
		Get In/Out of Bed				
		Climb Flight of 10 Stairs				
		Work Outdoors				
		Light Housework				
		Shop/Do Errands				
		Carry Groceries				
		Lift 5 lbs.				
		Lift 10 lbs.				
		Lift 20 lbs.				
		Lift 30 lbs.				
		Walk				
		Care for Children or Parents				
		Engage in hobbies: music or crafts, etc. Indicate hobby				
Describe other: eating/chewing difficulty: TMJ						

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
3	COMMUNICATION writing, typing, seeing, hearing, speaking	Write a Note				
		Type a Message on a Computer/Typewriter				
		See a Television Screen				
		Use a Telephone				
		Speak Clearly				
		Hear Clearly				
		Describe Others:				
4	NONSPECIFIED HAND ACTIVITIES: grasping, lifting, tactile, discrimination)	Pick Up Small Items				
		Turn a Knob on a Door				
		Write With a Pen/Pencil				
		Steer Wheel of Car				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
5	SENSORY FUNCTION: hearing, seeing, tactile feeling, tasting, smelling	Feel What You Touch				
		Taste What You Eat				
		Smell What You Eat				
		Describe Other:				
6	TRAVEL: riding, driving, flying	Get In/Out of a Car				
		Drive a Car				
		Ride in a Car				
		Fly in a Plane				
		Ride a Bicycle				
		Describe Other:				

	Category of Activity	Activity	Without Difficulty	With Some Difficulty	With Much Difficulty	Mostly Unable To Do
7	SEXUAL FUNCTION: orgasm, ejaculation, lubrication, erection	Engage in sexual activity				
		Describe specific difficulty: Orgasm, ejaculation, lubrication, erection				
8	SLEEP: restful sleep, nocturnal sleep pattern	Get to Sleep				
		Sleep Through the Night				
		Have Restful Sleep				
		Feel Refreshed After Sleep				
		Describe Specific Difficulty: (teeth grinding at night, excessive daytime fatigue, irritability, etc.)				

***This chart is meant to assist the examining physician to place the Applicant in certain impairment categories when determining whole person impairment under the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA) and in identifying body systems requiring referrals for Impairment evaluation.**

***Note: ADLS may indicate a serious condition requiring treatment.**

Cocchiarella, Linda, and B.J. Andersson Gunnar. Guides to the Evaluation of Permanent Impairment. Table 1-2: Activities of Daily Living. 5th Edition (2004). American Medical Association. 4.

EPWORTH SLEEPINESS SCALE

Patient Name: _____

Date: _____

Please rate your likelihood of falling asleep in the following situations: (circle a number in each row)

	Never	Sometimes	Most Times	Always
Sitting and Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting in a Public Place	0	1	2	3
Riding as a Passenger for 1 Hour	0	1	2	3
Taking an Afternoon Nap	0	1	2	3
Sitting and Talking to Someone	0	1	2	3
Sitting After a Non-Alcohol Lunch	0	1	2	3
Stopped in Traffic	0	1	2	3

TOTAL: _____ /24

Patient Signature: _____

Class 1: 1%-9% impairment of the whole person. Reduced daytime alertness; sleep pattern such that individual can perform most activities of daily living.

Class 2: 10%-29% impairment of the whole person. Reduced daytime alertness. Interferes with ability to perform some activities of daily living.

Class 3: 30%-69% impairment of the whole person. Reduced daytime alertness; ability to perform activities of daily living significantly limited.

Class 4: 70%-90% impairment of the whole person. Reduced daytime alertness; individuals unable to care for self in any situations or manner.

