

ATTENTION!

PLEASE READ BEFORE FILLING OUT FORMS

Please fill out the following:

- Recovery Progress Evaluation Form: Required
- Quadruple Analogue Scale: Required
- Outcomes Assessment Form: See below
 - You will only have to fill out the form that is specific to your condition. Choose the area of complaint and complete the form indicated. For Example: If you have only one area of complaint, you will fill out only one form. If you have more than one area than you will need to fill out multiple forms.
 - Neck Pain: Neck Disability index form
 - Low Back Pain: Oswestery Low Back Pain Form
 - Headaches: Headache Disability Index

We hope this will save you time in our office. If you have any questions feel free to call our office anytime.

Thanks

Doctor and Staff

RECOVERY PROGRESS EVALUATION

NAME _____ DATE _____

What problems brought you to our office?

To accurately evaluate your condition, and to accurately describe your progress to insurance companies, please answer the following questions, circle how often you suffer with it, and circle type of pain etc:

1. What is the MAIN problem/symptom you are having?

(Circle) all the time – most of the time – sometimes – a little - none
(Circle) stabbing – sharp – dull – numb – tingly – burning
What makes this worse or better? _____

Place an "X" through this line to rate your problem today:
| _____ |
No Pain Pain as bad as it can be

2. What is the NEXT MOST bothersome problem you are having?

(Circle) all the time – most of the time – some of the time – a little – none
(Circle) stabbing – sharp – dull – numb – tingly – burning
What makes this worse or better? _____

Place an "X" through this line to rate your problem today:
| _____ |
No Pain Pain as bad as it can be

3. What is the NEXT MOST bothersome problem you are having?

(Circle) all the time – most of the time – sometimes – a little – none
(Circle) stabbing – sharp – dull – numb – tingly – burning
What makes this worse or better? _____

Place an "X" through this line to rate your problem today:
| _____ |
No Pain Pain as bad as it can be

4. What is the NEXT MOST bothersome problem you are having?

(Circle) all the time – most of the time – sometimes – a little – none
(Circle) stabbing – sharp – dull – numb – tingly – burning
What makes this worse or better? _____

Place an "X" through this line to rate your problem today:
| _____ |
No Pain Pain as bad as it can be

What changes have been made in your general feelings? Are you (check all that apply):

Stronger _____ Less Pain _____ Appetite Better _____ Better Motion _____
Less Nervous _____ More Relaxed _____ More Alert _____ Improved Memory _____
Sleep Better _____ More Energy _____ No Changes _____ Better Concentration _____

What other benefits have you noticed since beginning your care? _____

Do you find it easier to (check all that apply):

Walking _____ Working _____ Sitting _____
Standing _____ Riding _____ Bending _____

Classify your improvement so far: Slow _____ Fair _____ Excellent _____
Have you followed Dr. Jay's instructions? Yes _____ No _____
Has anyone asked about your progress? Yes _____ No _____

Is there any other condition or problem you have, that we have not covered, that you now wish to go into?
Yes _____ No _____ If yes, please explain: _____

How were you treated by our staff? Excellent Good Fair

How would you rate your overall experience in our office? Excellent Good Fair

FEMALE: To the best of my knowledge, I am not pregnant, and I DO consent to having x-rays taken, if necessary.
Female Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

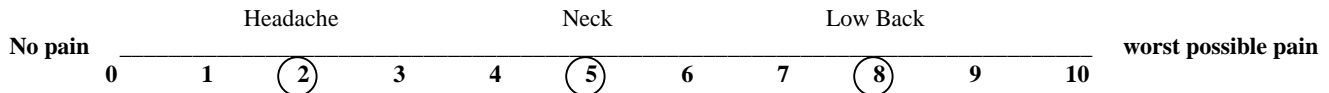
Date _____

Please read carefully:

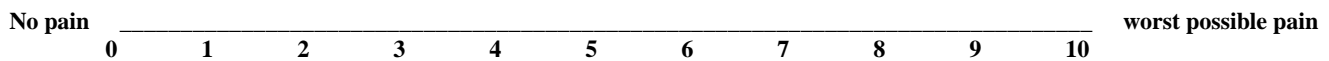
Instructions: Please circle the number that best describes the question being asked.

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.

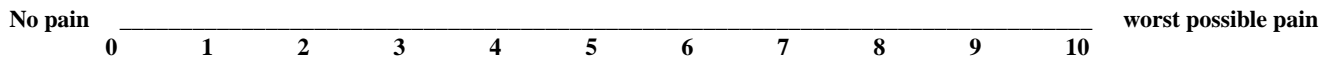
Example:



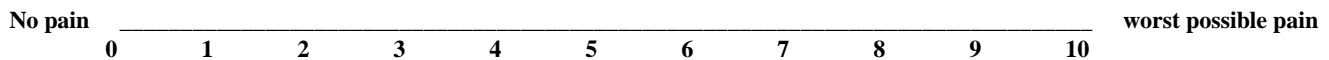
1 – What is your pain RIGHT NOW?



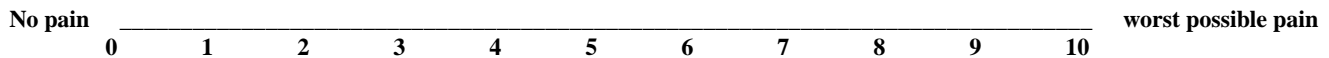
2 – What is your TYPICAL or AVERAGE pain?



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:

Examiner _____

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NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____

Date _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

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 without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in 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 extra pain.
- C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. 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 lift very light weights.
- F. I cannot lift or carry anything at all.

SECTION 4 – Reading

- A. I can read as much as I want with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want 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 – Headaches

- 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.

SECTION 6 – Concentration

- A. I can 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 have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7 – Work

- A. I can do as much work as I want to.
- B. I can only 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 any work at all.
- F. I cannot do any work at all.

SECTION 8 – Driving

- A. I can drive without any neck pain.
- B. I can drive as long as I want with slight pain in my neck.
- C. I can drive as long as I want with moderate pain in my neck.
- D. I cannot drive 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.
- B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- D. My sleep is moderately disturbed (2-3 hrs. sleepless).
- E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation

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

OTHER COMMENTS:

Examiner

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____

Date _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

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.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me sitting more than 1 hour.
- D. Pain prevents me sitting more than ½ hour.
- E. Pain prevents me sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

OTHER COMMENTS:

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Examiner

HEADACHE DISABILITY INDEX

Patient Name _____

Date _____

INSTRUCTIONS: Please CIRCLE the correct response:

- 1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
- 2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
_____	_____	_____	E1. Because of my headaches I feel handicapped.
_____	_____	_____	F2. Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3. No one understands the effect my headaches have on my life.
_____	_____	_____	F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	E5. My headaches make me angry.
_____	_____	_____	E6. Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7. Because of my headaches I am less likely to socialize.
_____	_____	_____	E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9. My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10. My outlook on the world is affected by my headaches.
_____	_____	_____	E11. I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	E12. I feel desperate because of my headaches.
_____	_____	_____	F13. I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	E14. My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15. I avoid being around people when I have a headache.
_____	_____	_____	F16. I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17. I am unable to think clearly because of my headaches.
_____	_____	_____	F18. I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	F19. I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20. I feel irritable because of my headaches.
_____	_____	_____	F21. I avoid traveling because of my headaches.
_____	_____	_____	E22. My headaches make me feel confused.
_____	_____	_____	E23. My headaches make me feel frustrated.
_____	_____	_____	F24. I find it difficult to read because of my headaches.
_____	_____	_____	F25. I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

Examiner