Patient Name ________________________________

In order to properly assess your condition, we must understand how much your BACK/LEG (SCIATIC) PAIN has affected your ability to manage everyday activities. For each item below, please circle the answer which most closely describes your PRESENT condition. (R = Right, L = Left, B = Both)

LOCATION OF PAIN □ NONE

<table>
<thead>
<tr>
<th>LOCATION OF PAIN</th>
<th>BACK</th>
<th>BUTTOX</th>
<th>HIPS</th>
<th>UPPER LEG (THIGH)</th>
<th>LOWER LEG (CALF)</th>
<th>FEET</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUMBAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>L</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHICH SIDE IS MORE PAINFUL? □ RIGHT □ LEFT □ EQUAL □ NOT APPLICABLE (N/A)

LOCATION OF NUMBNESS OR TINGLING □ NONE

<table>
<thead>
<tr>
<th>LOCATION OF NUMBNESS OR TINGLING</th>
<th>BACK</th>
<th>BUTTOX</th>
<th>HIPS</th>
<th>UPPER LEG (THIGH)</th>
<th>LOWER LEG (CALF)</th>
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<tbody>
<tr>
<td>LUMBAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>L</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHICH SIDE HAS LESS SENSATION? □ RIGHT □ LEFT □ EQUAL □ NOT APPLICABLE (N/A)

LOCATION OF WEAKNESS □ NONE

<table>
<thead>
<tr>
<th>LOCATION OF WEAKNESS</th>
<th>BACK</th>
<th>BUTTOX</th>
<th>HIPS</th>
<th>UPPER LEG (THIGH)</th>
<th>LOWER LEG (CALF)</th>
<th>FEET</th>
</tr>
</thead>
<tbody>
<tr>
<td>LUMBAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>L</td>
<td>B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHICH SIDE IS weaker? □ RIGHT □ LEFT □ EQUAL □ NOT APPLICABLE (N/A)

WHEN DID YOUR BACK/LEG (SCIATIC) PAIN BEGIN? __________________________________________

WHAT CAUSED YOUR PRESENT BACK/LEG (SCIATIC) PAIN TO START? (ONSET)

☐ Started Gradually ☐ Work Injury ☐ Motor Vehicle Accident ☐ Personal Injury ☐ No injury, Woke up with it ☐ Other

IF YOUR BACK PAIN STARTED AFTER AN INJURY, PLEASE DESCRIBE BRIEFLY.

____________________________________________________________________________________

HOW WOULD YOU DESCRIBE YOUR BACK/LEG (SCIATIC)? (CHARACTER)

☐ DULL ☐ SHARP ☐ THROBBING ☐ NAGGING ☐ PRESSURE
☐ ACHING ☐ SHOOTING ☐ BURNING ☐ STABBING ☐ OTHER
**BACK PAIN
NEW PATIENT HISTORY**

**ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF BACK PAIN? (BACK PAIN INTENSITY)**

<table>
<thead>
<tr>
<th>Current Level:</th>
<th>Average Level:</th>
<th>Lowest Level Past 24 HRS:</th>
<th>Highest Level Past 24 HRS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____/10</td>
<td>____/10</td>
<td>____/10</td>
<td>____/10</td>
</tr>
</tbody>
</table>

**ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF LEG (SCIATIC) PAIN? (LEG PAIN INTENSITY)**

<table>
<thead>
<tr>
<th>Current Level:</th>
<th>Average Level:</th>
<th>Lowest Level Past 24 HRS:</th>
<th>Highest Level Past 24 HRS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____/10</td>
<td>____/10</td>
<td>____/10</td>
<td>____/10</td>
</tr>
</tbody>
</table>

**HOW LONG HAS THE CURRENT EPISODE OF BACK/LEG (SCIATIC) PAIN BEEN PRESENT? (BACK PAIN DURATION)**

- [ ] Just Started
- [ ] 1-14 Days
- [ ] 2-4 Weeks
- [ ] 4-8 Weeks
- [ ] 2-3 Months
- [ ] 3-6 Months
- [ ] 6-9 Months
- [ ] 9-12 Months
- [ ] Years

**WHAT PORTION OF THE AVERAGE DAY DO YOU HAVE BACK/LEG (SCIATIC) PAIN? (BACK PAIN FREQUENCY)**

- [ ] None (0%/Day)
- [ ] Occasional (25%/Day)
- [ ] Intermittent (50%/Day)
- [ ] Frequent (75%/Day)
- [ ] Constant (100%/Day)

**WHAT TIME OF DAY IS THE BACK/LEG (SCIATIC) PAIN THE MOST SEVERE? (BACK PAIN TIMING)**

- [ ] Mornings
- [ ] End of day
- [ ] After activity
- [ ] Varies
- [ ] Constant
- [ ] With Sleep

**HOW HAVE THE EPISODES OF BACK/LEG (SCIATIC) PAIN CHANGED SINCE THEY STARTED? (BACK PAIN EVOLUTION)**

- [ ] Worsening
- [ ] Slightly Worse
- [ ] Unchanged
- [ ] Slightly Improved
- [ ] Improving

**DO YOU HAVE LIMITED MOVEMENT OF THE BACK OR STIFFNESS? (BACK ROM)**

- [ ] None
- [ ] Mild Limitation
- [ ] Moderate Limitation
- [ ] Severe Limitation

**DO YOU HAVE BACK MUSCLE SPASMS? (BACK SPASMS)**

- [ ] None
- [ ] Mild
- [ ] Moderate
- [ ] Severe

**WHICH OF THE FOLLOWING BEST DESCRIBES YOUR BACK/LEG (SCIATIC) PAIN? (BACK/LEG RATIO) □ NONE**

| Only the Back hurts 100%Back/0%Leg | Back hurts much more than Leg 90%Back/10%Leg | Back hurts a little more than Leg 75%Back/25%Leg | Back hurts about the same as Leg 50%Back/50%Leg | Back hurts a little less than Leg 25%Back/75%Leg | Back hurts much less than Leg 10%Back/90%Leg | Only the Leg hurts 0%Back/100%Leg |

**BACK PAIN AGGRAVATION/RELIEF**

**WHAT TENDS TO MAKE YOUR BACK/LEG (SCIATIC) PAIN WORSE? (PAIN AGGRAVATION) □ NONE**

<table>
<thead>
<tr>
<th>Bending</th>
<th>Squatting</th>
<th>Twisting</th>
<th>Lifting</th>
<th>Sitting</th>
<th>Standing</th>
<th>Walking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kneeling</td>
<td>Crawling</td>
<td>Leaning</td>
<td>Activity</td>
<td>Work</td>
<td>Laying Down</td>
<td>Stress</td>
</tr>
<tr>
<td>Cough/Sneeze</td>
<td>Bowel Movement</td>
<td>Driving/Travel</td>
<td>Recreation</td>
<td>Housework</td>
<td>Weather Change</td>
<td>Sleep</td>
</tr>
</tbody>
</table>

**WHAT TENDS TO MAKE YOUR BACK/LEG (SCIATIC) PAIN BETTER? (PAIN RELIEF) □ NONE**

<table>
<thead>
<tr>
<th>Heat</th>
<th>Ice</th>
<th>Inactivity</th>
<th>Certain Positions</th>
<th>Laying Down</th>
<th>Activity</th>
<th>Walking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>Therapy</td>
<td>Stretching</td>
<td>Injections</td>
<td>Massage</td>
<td>Brace</td>
<td>TENS</td>
</tr>
<tr>
<td>Change Mattress</td>
<td>Chiropractic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER-**

**OTHER-**
PAST EPISODES OF BACK PAIN

HOW MANY TIMES HAVE YOU BEEN TREATED FOR BACK/LEG (SCIATIC) PAIN IN THE PAST? (NUMBER OF PRIOR EPISODES)

☐ I Have Never Been Treated for Back/Leg (Sciatic) Pain in the Past  ☐ A Few Times  ☐ Several Times  ☐ Many Times  ☐ Constant

HOW LONG AGO WAS THE LAST EPISODE OF BACK/LEG (SCIATIC) PAIN? (TIME SINCE PRIOR EPISODE)

☐ None  ☐ Days  ☐ Weeks  ☐ Months  ☐ Years  ☐ Constant

HOW LONG DID THE LAST EPISODE OF BACK/LEG (SCIATIC) PAIN LAST? (DURATION OF PRIOR EPISODES)

☐ None  ☐ Days  ☐ Weeks  ☐ Months  ☐ Years  ☐ Constant

HOW HAVE THE EPISODES OF BACK/LEG (SCIATIC) PAIN CHANGED SINCE THEY STARTED? (FREQUENCY OF PRIOR EPISODES)

☐ None  ☐ Much More Often  ☐ Slightly More Often  ☐ No Change in Frequency  ☐ Slightly Less Often  ☐ Much Less Often

GAIT AND BALANCE SYMPTOMS

DO YOU HAVE ANY PROBLEMS WALKING? (GAIT DISTURBANCE SEVERITY)

☐ No Problem Walking  ☐ Mild Problem Walking  ☐ Moderate Problem Walking  ☐ Severe Problem Walking

HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR WALKING? (GAIT DISTURBANCE DURATION)

☐ N/A  ☐ A Few Days  ☐ A Few Weeks  ☐ A Few Months  ☐ 6 Months or More  ☐ One year or More

DO YOU HAVE PROBLEMS WITH YOUR BALANCE, SUCH AS FREQUENT FALLING? (BALANCE SYMPTOMS SEVERITY)

☐ No Balance Problems  ☐ Mild Balance Problems  ☐ Moderate Balance Problems  ☐ Severe Balance Problems

HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR BALANCE OR COORDINATION? (BALANCE DURATION)

☐ N/A  ☐ A Few Days  ☐ A Few Weeks  ☐ A Few Months  ☐ 6 Months or More  ☐ One year or More

DO YOU USE ANY DEVICES TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES)

☐ None  ☐ Cane  ☐ Crutches  ☐ Walker  ☐ Wheelchair  ☐ Scooter

HOW LONG HAVE YOU USED THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES DURATION)

☐ N/A  ☐ A Few Days  ☐ A Few Weeks  ☐ A Few Months  ☐ 6 Months or More  ☐ One year or More

WHY DO YOU USE THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES NECESSITY)

☐ N/A  ☐ To Relieve Stress on the Back  ☐ For Weak Leg(s)  ☐ For Balance Problems  ☐ Other

WORK STATUS

ARE YOU WORKING AT THIS TIME? (WORK STATUS)

☐ Yes – Full Duty  ☐ Yes – with Restrictions  ☐ Not Working – due to illness  ☐ Not Working – by choice  ☐ Unemployed  ☐ Retired  ☐ Disabled

OCCUPATION - ____________________________________________________________
ASSOCIATED SYMPTOMS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (SYSTEMIC SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>frequent fevers or chills</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>generalized weakness or fatigue</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>unplanned weight loss greater than 10 lbs</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>recent trauma, fall or accident</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>night pain that wakes you up from sleep</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>night pain that stops you from falling asleep</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CAUDA EQUINA SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have loss of bladder control?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you have loss of bowel control?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you have numbness in the genital region?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (NEUROGENIC CLAUDICATION SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have numbness or tingling in the legs CAUSED by walking and RELIEVED by bending over forward</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (SHOPPING CART SIGN SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you able to walk farther while leaning over and holding on to a shopping cart?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (PERIPHERAL NEUROPATHY SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been diagnosed with peripheral neuropathy?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (HIP SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have pain in the groin region?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you have limited movement of the hips?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (VASCULAR SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been diagnosed with poor circulation in the legs?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Have you been diagnosed with an aneurysm?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (OTHER SYMPTOMS)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>New (&lt;1 Month)</th>
<th>Old (&gt;1 Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>treatment for anxiety</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>treatment for depression</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>treatment for fibromyalgia</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>treatment for chronic pain</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>treatment for alcohol abuse</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>treatment for drug abuse</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
Please Read: This questionnaire is designed to give the doctor information as to how your back/leg (sciatic) pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section may relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity
- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

Section 2 – Personal Care
- I would not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even thought it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (Skip if you have not attempted lifting since the onset of your low back pain).
- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if conveniently positioned (on a table).
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift light weights at the most.

Section 4 – Walking
- I have no pain on walking.
- I have some pain on walking, but I can still walk my required normal distances.
- Pain prevents me from walking long distances.
- Pain prevents me from walking intermediate distances.
- Pain prevents me from walking even short distances.
- Pain prevents me from walking at all.

Section 5 – Sitting
- Sitting does not cause me any pain.
- I can sit as long as I need provided I have my choice of sitting surfaces.
- 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.

Section 6 – Standing
- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I can’t stand for more than 1 hr without increasing pain.
- I can’t stand for more than ½ hr without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

Section 7 – Sleeping
- I get no pain in bed.
- I get some pain while traveling, but it does not prevent me from sleeping well.
- Because of pain, my night’s sleep is only ¾ of normal.
- Because of pain, my night’s sleep is only ½ of normal.
- Because of pain, my night’s sleep is only ¼ of normal.
- Pain prevents me from sleeping at all.

Section 8 – Social Life
- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities (sports, dancing, etc.).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

Section 9 – Traveling
- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- I get some pain while traveling, but it does not make me seek alternative forms of travel.
- I get extra pain while traveling which requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done while lying down.

Section 10 – Employment/Homemaking
- My normal job/homemaking activities do not cause pain.
- My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (lifting, vacuuming, etc.).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from even light duties.
- Pain prevents me from performing any job or homemaking chore.

RAW Score X 2 = Oswestry Low Back Pain Disability Score
0-20 – mild; 20-40 – moderate; 40-60 – severe; >60 – very severe.
**PAST LUMBAR SPINE TREATMENT**

**Diagnostic Tests**

**HAVE YOU HAD ANY DIAGNOSTIC TESTING DONE ON YOUR LOWER BACK?**

- Back X-ray
- Back MRI
- CT-Myelogram
- EMG/NCV Nerve Test
- Discogram
- Bone Scan
- Bone Density

**Past Treatments**

**IN THE PAST ONE YEAR HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR BACK/LEG (SCIATIC) CONDITION?**

- Medications
- Physical Therapy
- Massage Therapy
- Back Brace
- Chiropractic
- TENS Unit
- Epidural Injections (ESI’s)
- Other

**Medications**

**PLEASE LIST ALL MEDICATIONS YOU HAVE TAKEN FOR YOUR BACK/LEG (SCIATIC) CONDITION IN THE PAST SIX MONTHS.**

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR YOUR BACK/LEG (SCIATIC) CONDITION.**

**Physical Therapy**

*Have you been treated with PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition?*

- Yes
- No

*When did you go to PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition?*

*How long did you go to PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition?*

*Did the PHYSICAL THERAPY help your BACK/LEG (SCIATIC) condition?*

**Epidural Injections**

*Have you been treated with EPIDURAL STEROID INJECTIONS for your BACK/LEG (SCIATIC) condition?*

- Yes
- No

*How many EPIDURAL STEROID INJECTIONS have you had for your BACK/LEG (SCIATIC) condition?*

*When was the last EPIDURAL STEROID INJECTIONS for your BACK/LEG (SCIATIC) condition?*

*How long do the EPIDURAL STEROID INJECTIONS usually last for your BACK/LEG (SCIATIC) condition?*

**Surgery**

**PLEASE LIST ANY PREVIOUS LOWER BACK SURGERY. PLEASE INCLUDE DATES, HOSPITAL, CITY AND PHYSICIAN IF KNOWN.**

**DID THE SURGERY HELP YOUR BACK/LEG (SCIATIC) CONDITION?**

**DID YOU HAVE ANY COMPLICATIONS WITH YOUR BACK SURGERY?**