PLEASE ANSWER EVERY QUESTION!

BACK AND LEG PAIN ASSESSMENT

1. NAME: _____ DATE TODAY: _____

2. AGE: _____ SEX: _____

3. PRESENTLY EMPLOYED? ☐ No ☐ Yes, How long there? _____

   DO YOU LIKE YOUR WORK? ☐ Yes ☐ No, Why Not? _____

   _____

4. PRESENT OCCUPATION: _____ **(Fill In)**

   PRIOR OCCUPATION: _____ **(Fill In)**

   Your activities at work or at home **mostly** involve:

   (Check one or two)
   - ☐ Manual labor, heavy lifting most of the day
   - ☐ Manual labor, less strenuous
   - ☐ Sitting most of the day
   - ☐ Walking or standing most of the day
   - ☐ House and child care
   - ☐ Other; Explain _____

   Is your work too heavy or hard? ☐ No ☐ Yes; Why? _____

   _____

5. IF EMPLOYED, ARE YOU **OFF WORK** NOW? ☐ Yes ☐ No ☐ N/A (Does Not Apply)

6. IF YES, WHEN WAS IT YOU LAST WORKED? **(Give date)**: _____

7. IF YOU ARE NOT WORKING, IS IT BECAUSE OF BACK OR LEG PAIN? ☐ Yes ☐ No

8. DO YOU HAVE MORE PAIN IN YOUR (Check which):
   - ☐ Back
   - ☐ Hip(s) – R ☐ L ☐
   - ☐ Leg(s) – R ☐ L ☐

9. BEFORE NOW, HAVE YOU HAD ANY PROBLEMS IN THE PAST WITH LOW BACK PAIN? ☐ No ☐ Yes;

   IF NO, GO TO QUESTION 24. IF YES, GO TO NEXT QUESTION.

10. WHEN DID YOU BACK OR LEG TROUBLE VERY FIRST START? **(Check One)**:

    ☐ Started years ago, recurring or persisting since that time; give approximate date or year: _____

    ☐ Started within the last year or so; give date: _____

    ☐ Started weeks to months ago; give date: _____

11. HOW DID THE PAIN AT THAT TIME **(NOT THIS TIME)** VERY FIRST START? **(Check all that apply)**:

☐ After lifting, ☐ after pulling/pushing, ☐ after twisting

☐ After falling

☐ After slipping

☐ Auto accident

☐ Direct blow

☐ Other injury

☐ Uncertain how started

☐ Following some activity (coughing, straining, sports, other)

12. HOW DID THE PAIN FIRST START AT THAT TIME? **(Check One)**:

☐ Suddenly ☐ Can't remember

☐ Slowly with gradual worsening ☐ Does not apply

13. HAVE YOU EVER HAD SURGERY ON YOUR BACK? ☐ Yes ☐ No

IF NO PLEASE SKIP TO QUESTION 24.

14. GIVE INFORMATION ON YOUR PREVIOUS BACK SURGERIES:

Date(s)	**Procedure**	**Surgeon(s)**	**Hospital(s)**

15. HOW LONG DID YOU HAVE PAIN BEFORE YOUR OPERATION **(1st OPERATION)**? **(Fill in approximate number):**

_____Weeks

_____Months

_____Years

16. BEFORE YOUR BACK OPERATION **(1st OPERATION)** DID YOU HAVE MORE **(Check which):**

☐ Back pain, Which side more? ☐ Right ☐ Left ☐ Both

or

☐ Leg pain, Which side more? ☐ Right ☐ Left ☐ Both

17. BEFORE YOUR OPERATION **(1st OPERATION)** PLEASE MARK AGAIN WHICH LEG HAD MORE PAIN IN IT?

☐ Right more, ☐ Right only

☐ Left more, ☐ Left only

☐ Both equally ☐ Neither

18. BEFORE YOUR OPERATION **(LAST OPERATION)** WHICH LEG HAD MORE PAIN IN IT?

_____ Right more,
_____ Right only
_____ Left more,
_____ Left only
_____ Both equally
_____ Neither
_____ Same as above as I have only had one back operation.

19. WHICH LEG HAS MORE PAIN IN IT NOW?

_____ Right more,
_____ Right only
_____ Left more,
_____ Left only
_____ Both equally
_____ Neither

20. SOON AFTER YOUR BACK OPERATION **(LAST OPERATION)** WAS YOUR BACK PAIN:

_____ Gone
_____ Same
_____ Much better
_____ Worse
_____ Better
_____ Much worse
_____ Does not apply

21. DID YOU HAVE A PERIOD OF TIME WHEN THE PAIN WAS AT LEAST SOMEWHAT IMPROVED AFTER YOUR OPERATION **(LAST OPERATION)**?

_____ Yes, About how long? _____
_____ No

22. HOW LONG AFTER YOUR OPERATION **(LAST OPERATION)** WAS IT APPROXIMATELY UNTIL YOU RETURNED TO WORK?

Part-time and/or light duties _____ Months (Fill in)

Full-time and/or full duties _____ Months (Fill in)

Never able to return _____ (Check)

23. FILL IN APPROXIMATE NUMBER OF TOTAL DAYS OFF WORK (OR UNABLE TO DO HOUSEWORK) DURING THE LAST:

3 weeks → days_____
6 weeks → days_____
3 months → days_____
6 months → days_____
12 months → days_____
24 months → days_____

(IF NO DAYS OFF, _____ **Check**)

If you are off work now, give date you last worked: _____

24. WHAT STARTED OR MADE YOUR PAIN WORSE **(THIS TIME)? (Check all that apply):**

☐ After lifting, ☐ after pulling/pushing, ☐ after twisting

☐ After falling

☐ After slipping Notes:

☐ Auto accident

☐ Direct blow

☐ Other injury

☐ Uncertain how started

☐ Following some activity (coughing, straining, sports, other)

☐ Does not apply as this is the same pain or almost the same pain that I had before my operation **(last operation)**

25. ABOUT HOW MANY DAYS, WEEKS OR MONTHS HAS <u>THIS CURRENT PAIN</u> NOW BEEN WITH YOU?

_____Days

_____Weeks **(Must fill in <u>approximate</u> number)**

_____Months

26. IS YOUR <u>LEG</u> PAIN <u>NOW</u> **(Check <u>One</u>):**

☐ Gone

☐ Getting much better

☐ Getting better slowly

☐ Staying about the same

☐ Getting worse slowly

☐ Getting worse rapidly

☐ Getting much worse rapidly

☐ Does not apply as I don't have any leg pain

27. IS YOUR <u>LEG PAIN</u> OR DISCOMFORT **GENERALLY (Check all that apply):**

☐ Sharp and shooting

☐ Cramping or spasms

☐ Pins and needles

☐ Numbness

☐ Tingling

☐ Burning

☐ Throbbing

☐ Aching

☐ Coldness

☐ Again, does not apply

28. DID YOU HAVE LEG PAIN LIKE YOU DO NOW BEFORE YOUR **LAST OPERATION**?

☐ No or Does not apply ☐ Yes; Which leg? _____

29. IS YOUR BACK PAIN NOW **(Check One):**

☐ Gone
☐ Getting much better
☐ Getting better slowly
☐ Staying about the same
☐ Getting worse slowly
☐ Getting worse rapidly
☐ Getting much worse rapidly
☐ Does not apply as I don't have any back pain

30. HAVE YOU HAD RECURRENT ATTACKS OF LOW BACK PAIN SINCE YOUR OPERATION **(LAST OPERATION)**?

☐ No ☐ Yes; About how many? _____ When Last? _____

31. IF THE PAIN HAS TENDED TO COME AND GO HAVE THE ATTACKS BECOME MORE FREQUENT AND MORE EASILY BROUGHT ON? **(Check One):**

☐ Yes Notes:
☐ No
☐ Attacks remaining about the same (in terms of frequency)
☐ Does not apply

32. ARE THE ATTACKS LASTING LONGER AND BECOMING MORE DISABLING TO YOU? **(Check One):**

☐ Yes; About how long do they usually last now? _____
☐ No
☐ Attacks remaining about the same (in terms of duration and severity)
☐ Again, this does not apply

33. DOES YOUR LOW BACK EVER **"GO OUT"** SUCH THAT YOU CANNOT STAND, WALK, BEND OR MOVE ABOUT FOR VARYING PERIODS OF TIME?

☐ Yes; If yes, about how many times in the last year? _____**(Fill in)**
☐ No

34. ARE YOU MOSTLY OR FREQUENTLY (circle which) HOUSE OR BED BOUND BECAUSE OF YOUR BACK?

☐ Yes HOUSE BOUND ☐ BED BOUND ☐
☐ No

35. HOW MANY **DOCTORS** AND **CHIROPRACTORS** HAVE YOU SEEN SINCE BEING RELEASED OR REFERRED BY THE PHYSICIAN WHO DID YOUR SURGERY **(FIRST SURGERY)**?

Doctors (Give names, dates):

Chiropractors (Give names, dates):

36. HAVE YOU HAD MANIPULATIONS OR ADJUSTMENTS? _____☐No _____☐Yes: How Many? _____

By Whom? _____ Did they help? _____

37. ANY PHYSICAL THERAPY TREATMENTS? _____No _____Yes; **(Fill in number)**

Are you doing any back exercises now? ____☐No _____☐Yes; ____☐Flexion? ____☐Extension? ____☐Don't Know?

Have you done any back exercises in the past? ____☐No ____☐Yes; When? _____

Have you ever worn a brace? _____☐No _____☐Yes; What period of time? _____

_____

38. HAVE YOU HAD SPINAL BLOCKS (EPIDURALS) FOR THIS PROBLEM ____☐No ____☐Yes;

How many? _____ Any help? _____

By Whom? _____ When? _____

39. HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED FOR BACK OR LEG PAIN SINCE YOUR FIRST BACK OPERATION?

_____ Total Number; List Hospitals and Doctors:

40. HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED FOR BACK OR LEG PAIN SINCE YOUR LAST BACK OPERATION?

_____ Total Number; List Hospitals and Doctors:

41. HOW MANY MYELOGRAMS HAVE YOU HAD?

_____Total Number; When was your myelogram **(last myelogram)** done?

Give date: _____ Where? _____

42. WHAT PAIN AND/OR NERVE MEDICINE(S), INCLUDING ASPIRIN, TYLENOL AND OTHER PAIN RELIEVERS HAVE YOU BEEN TAKING? (BOTH PRESCRIPTION AND NON PRESCRIPTION)

_____None ever; _____None now: was taking **(list)**: _____

_____

43. DID YOU HAVE A HAPPY CHILDHOOD _____Yes _____No;

If not, did you suffer:

Physical and/or sexual abuse?	_____Yes	_____No
Abandonment and/or emotional neglect or abuse?	_____Yes	_____No
One or both parents alcoholic and/or drug users?	_____Yes	_____No
Parents separating and/or divorcing?	_____Yes	_____No

44. HAVE YOU EVER BEEN EVALUATED FOR MENTAL OR EMOTIONAL PROBLEMS?

_____No _____Yes; Were you ever hospitalized for these problems? _____No _____Yes;

When, Where & Why? _____

_____

_____

PAIN DRAWING – VERY IMPORTANT!

Show by marking and drawing on the front and back of the figures below where you are having any:

Aching and/or pain

Numbness and/or tingling

Pins and/or needles

Burning

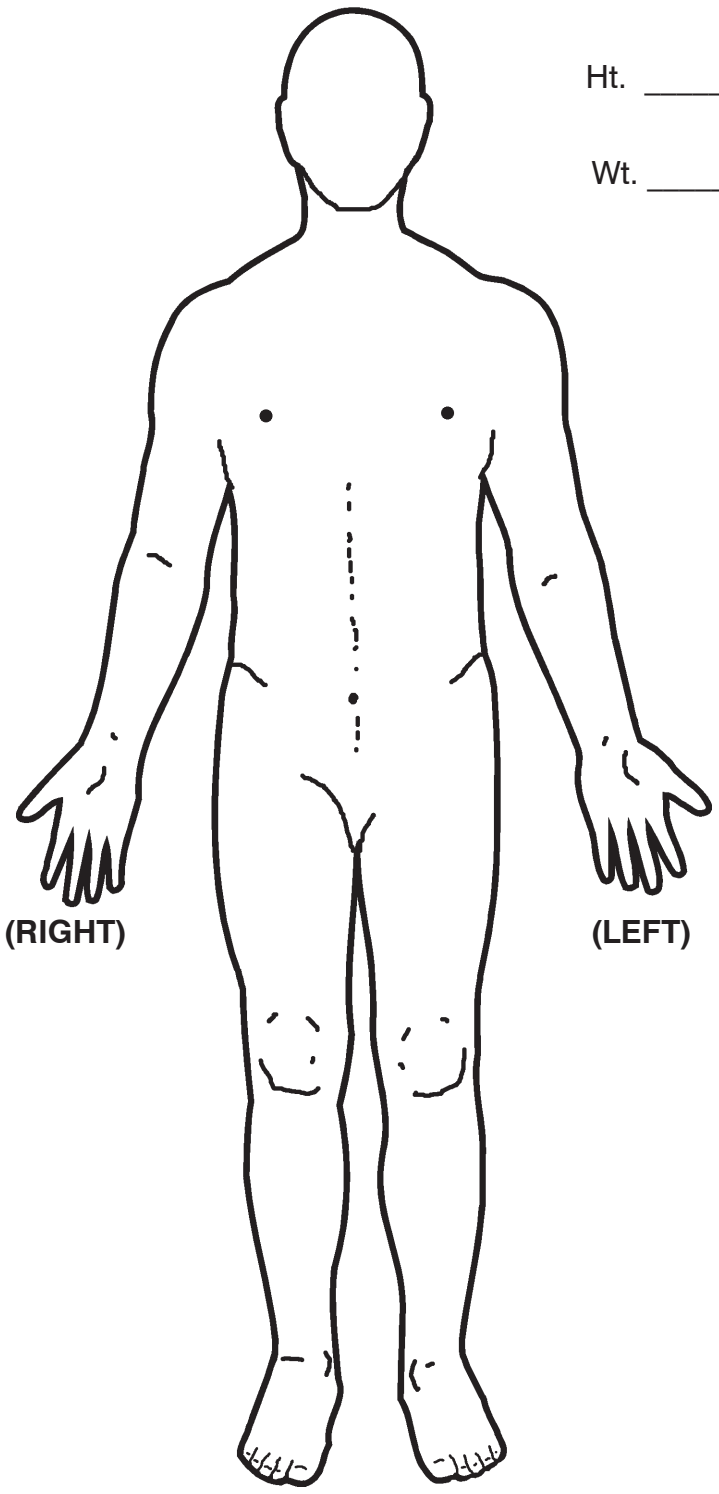
Spasms and/or cramps

(Draw arrows or indicate where pain goes or shoots. Show all areas involved)

FRONT

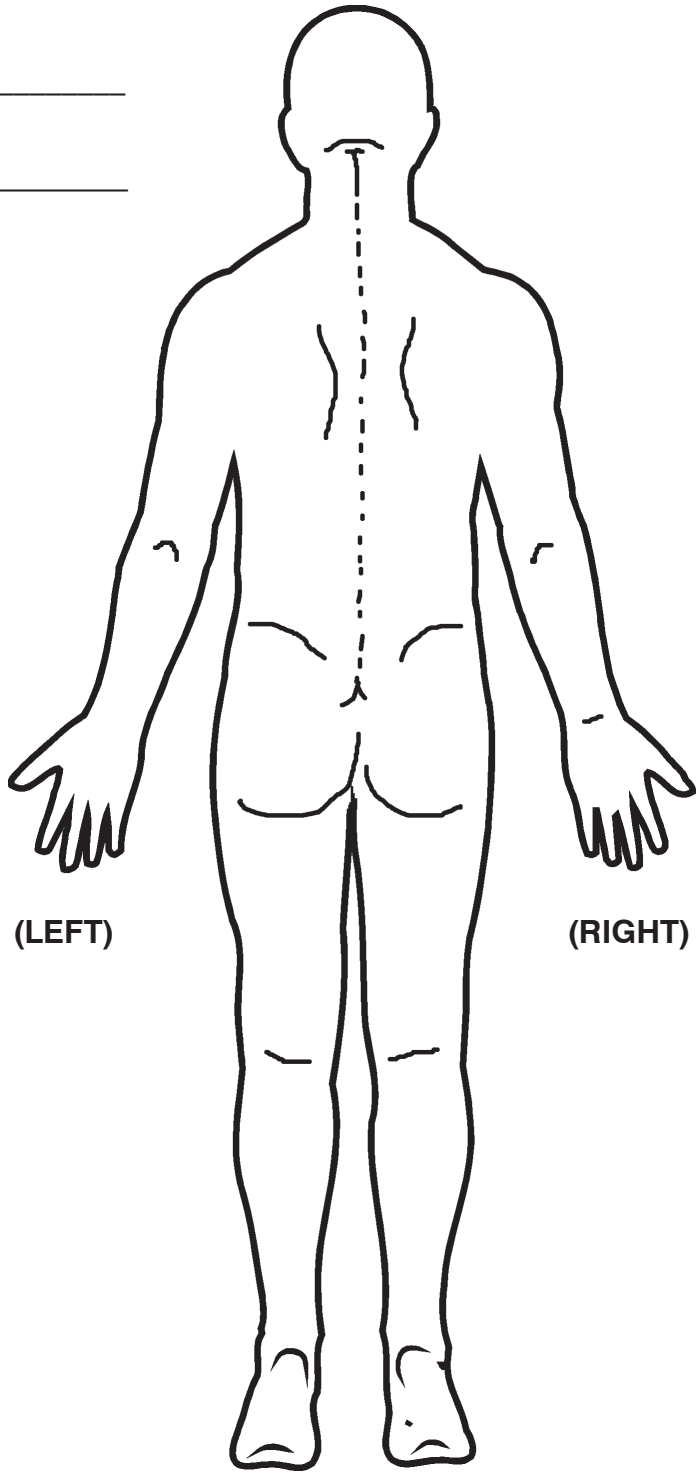
Ht. _____

Wt. _____



(RIGHT) **(LEFT)**

BACK



(LEFT) **(RIGHT)**

Please mark or indicate where the pain is worse now

PLEASE ANSWER!!

USING A SCALE OF ZERO TO TEN, CIRCLE YOUR LEVEL OF PAIN WHEN IT IS A GOOD DAY AND WHEN IT IS A BAD DAY. (CHECK ONLY ONE NUMBER IN EACH COLUMN).

GOOD DAY	BAD DAY	DEFINITIONS OF PAIN LEVEL
☐ 0	☐ 0	No pain.
☐ 1	☐ 1	Mild pain or discomfort that I am sometimes aware of.
☐ 2	☐ 2	Dull pain that I can tolerate without medication.
☐ 3	☐ 3	Moderate pain, worse at times that I can mostly tolerate without pain medication
☐ 4	☐ 4	Harder aching pain, frequently worse at times (medication often required).
☐ 5	☐ 5	
☐ 6	☐ 6	More severe pain. Pain medication required.
☐ 7	☐ 7	
☐ 8	☐ 8	Very severe pain.
☐ 9	☐ 9	
☐ 10	☐ 10	Extreme pain, most severe pain.

BACK PROBLEMS IN THE PAST

THE FOLLOWING 4 QUESTIONS ARE ABOUT ANY BACK PROBLEMS YOU MAY HAVE HAD IN THE PAST. THEY AID US IN HELPING YOU. WE UNDERSTAND THAT THIS IS DIFFICULT. PLEASE CHOOSE THE ONES THAT MOST CLOSELY DESCRIBE YOUR PAIN AND DISABILITY PRIOR TO YOUR BACK OPERATION (FIRST BACK OPERATIONS)

1. HOW OFTEN WERE YOU HAVING BACK PAIN BEFORE YOU HAD ANY BACK SURGERY? (**Check One Only**):

   ☐ No pain or rarely had back pain
   ☐ Occasional back pain (once or twice per year or less)
   ☐ Recurrent back pain (a few days every few months or more often)
   ☐ Frequent back pain (a few or more days at least every month)
   ☐ Very frequent back pain (every week or more often; almost every day)
   ☐ Back pain every single day (Was it constant? Yes ___ No___)

2. BEFORE YOU EVER HAD BACK SURGERY, WHEN YOU HAD BACK PAIN, WAS IT GENERALLY? (**Check One Only**):

   ☐ A mild discomfort or less
   ☐ A dull pain, worse at times
   ☐ A harder aching pain, frequently worse at times
   ☐ A severe pain, even sharp and shooting at times
   ☐ A very severe pain, frequently sharp, shooting and disabling
   ☐ An extremely severe and disabling pain

3. HOW MUCH HAD BACK PAIN LIMITED YOUR JOB AND/OR HOUSEWORK BEFORE YOU HAD ANY BACK SURGERY? (**Check One Only**):

   ☐ Not limited in any way now
   ☐ Pain had not bad enough to really limit me very much
   ☐ Was able to work with back pain all the time by modifying my activities
   ☐ Had to stop and rest and greatly limit activities, but able to work most of the time
   ☐ Frequently was unable to work for several or more days at a time
   ☐ Unable to work at all - totally disabled by back pain (Since when? _____)

4. HOW MUCH HAD BACK PAIN LIMITED YOUR SOCIAL AND OTHER LEISURE ACTIVITIES BEFORE YOU HAD BACK SURGERY? **(Check One Only)**:

   ☐ Not limited in any way now
   ☐ Back pain had not been bad enough to really limit me very much
   ☐ Was able to do most things even with back pain
   ☐ Had to modify activities a lot to control pain and not do some things
   ☐ Had to greatly limit all activities to control my back pain and not do most things
   ☐ Was unable to engage in any of these activities whatsoever due to back pain

BACK AND LEG PAIN ASSESSMENT
NOW

Again, do you have more pain in your:
BACK _____ **R** ____ **L** ____
HIP(S) _____ **R** ____ **L** ____
LEG(S) _____ **R** ____ **L** ____
OTHER _____

If you have been off work, give:

Date returned to some work: _____ Full Duties: _____

If you are **Still Off, Unemployed** and/or **On Disability (circle which ones)**

Please answer the following 4 questions about your pain as best you can. We understand that this is difficult. Choose the responses that most closely describe your pain presently.

1. HOW **OFTEN** ARE YOU HAVING PAIN NOW? (✓ **One**):
   - ____ No pain or rarely have pain now
   - ____ Occasional pain (about once or twice per year or so)
   - ____ Recurrent pain (a few days ever few months or more often)
   - ____ Frequent pain (a few or more days at least every month if not more)
   - ____ Very frequent pain (every week or more often; almost every day)
   - ____ Pain every single day (Is this constant? Yes ___ No___)

2. WHEN HAVING PAIN, IS IT **GENERALLY** (✓ **One**):
   - ____ A mild discomfort or less
   - ____ A dull pain, worse at times
   - ____ A harder aching pain, frequently worse at times
   - ____ A severe pain, even sharp and shooting at times
   - ____ A very severe pain, frequently sharp, shooting and disabling
   - ____ An extremely severe and disabling pain

3. HOW IS THE PAIN NOW LIMITING YOUR **JOB** AND/OR **HOUSEWORK**? (✓ **One**):
   - ____ Not limited in any way now
   - ____ Pain not bad enough to really limit me very much now
   - ____ Able to work with pain all the time by modifying my activities
   - ____ Must stop and limit activities, but able to work most of the time
   - ____ Frequently unable to work for several or more days at a time
   - ____ Unable to work at all - totally disabled by pain

4. HOW IS PAIN NOW LIMITING YOUR SOCIAL, RECREATIONAL AND **OTHER ACTIVITIES**? (✓ **One**):
   - ____ Not limited in any way now
   - ____ Pain not bad enough to really limit me very much
   - ____ Able to do most things most of the time even with pain
   - ____ Must modify activities to control pain and not do some things
   - ____ Must greatly limit activities to control pain and not do most things
   - ____ Unable to engage in any of these activities whatsoever due to pain

45. WHICH OF THE FOLLOWING SEEM TO MAKE THE PAIN OR PROBLEM A LOT **WORSE**?

☐ Exercise (during)
☐ Exercise (after)
☐ Prolonged sitting
☐ Prolonged standing
☐ Arching backwards
☐ Bending over forwards
☐ Bending to the right side
☐ Bending to the left side
☐ Twisting to the right
☐ Twisting to the left
☐ Walking (at first)
☐ Walking (later on)
☐ Getting in or out of cars and chairs
☐ Driving a car
☐ Coughing
☐ Sneezing
☐ Straining at stool
☐ Lifting
☐ Climbing stairs
☐ Putting on socks, stockings and/or shoes
☐ Weather changes (rain, etc.)
☐ Heat _____Cold
☐ Resting _____Nothing
☐ Other things: List_____

Notes:

Do you get cramping or aching in your calf(s) when walking? ☐ No ☐ Yes;

What must you do to get relief? _____

Has your walking gotten more and more limited? ☐ No ☐ Yes;

How far can you walk now without stopping? _____

Do you have more trouble walking up and/or down hills or slopes? (Circle which or Circle Neither)

46. WHICH OF THE FOLLOWING SEEM TO MAKE THE PAIN OR PROBLEM **BETTER**?

☐ Rest
☐ Lying down
☐ Heat
☐ Cold
☐ Exercise (during)
☐ Exercise (after)
☐ Walking
☐ Changing Positions
☐ Manipulations
☐ Lying flat on back
☐ Lying on side with hips and knees curled up
☐ Injections for pain
☐ Pain pills
☐ Muscle relaxers
☐ Aspirin or anti-inflammatory pills
☐ Other medications
☐ Alcohol
☐ Nothing
☐ Other things: List_____

47. IS THE PAIN **GENERALLY** MOST SEVER WHEN YOU ARE **(Check one):**

☐ Active ☐ Inactive ☐ Makes no difference

48. HOW LONG (MINUTES, HOURS OR UNLIMITED) CAN YOU?

_____Lie down in one position
_____Sit in one position
_____Stand in one position
_____ Walk
_____ Shop
_____ Drive

49. IS THE PAIN **USUALLY** WORSE **(Check the one that fits you best)**:

☐ In the morning when you first get up ☐ In the evening

☐ As the day progresses ☐ At night in bed

50. DO YOU WAKE UP BECAUSE OF PAIN? ☐ No ☐ Yes; What must you do to get relief? _____

_____

51. DO YOU HAVE TROUBLE SLEEPING? ☐ No ☐ Yes; Why? _____

_____

52. DO YOU GET LEG CRAMPS AT REST? ☐ No ☐ Yes; Mostly during the **day** ☐ or **night**? ☐

53. ANY OTHER JOINTS HURT? **(Describe)**:

54. HAVE YOU **GAINED** ANY WEIGHT RECENTLY? ☐ No ☐ Yes; **HOW MUCH**? _____

55. HAVE YOU **LOST** ANY WEIGHT RECENTLY? ☐ No ☐ Yes; **HOW MUCH**? _____

56. HAVE YOU HAD ANY **BLADDER** PROBLEMS? ☐ No ☐ Yes; What? _____

_____

57. HAVE YOU HAD ANY **BOWEL** PROBLEMS? ☐ No ☐ Yes; What? _____

_____

58. ANY PROBLEMS WITH PERIODS? **(Women)** ☐ No ☐ Yes; What? _____

_____

59. DO YOU HAVE ANY REASONS TO BE EMOTIONALLY UPSET? ☐ No ☐ Yes; What? **(Please check and explain)**

☐ Financial ☐ Work Comments:

☐ Marital ☐ Legal

☐ Social ☐ Other

60. DO YOU HAVE ANY ADDITIONAL INFORMATION THAT WOULD BE HELPFUL IN UNDERSTANDING YOUR PROBLEM?

_____

_____

_____

_____

_____

DO NOT FILL OUT THIS PAGE EXAM DATE: _____

Equipment –

Gait –

Toes

Heels

Stance – Balance

Scoliosis

Kyphosis

Lordosis

Abdomen

Pelvis –

Back –

Scars

Tender

Spasm

Compression – Iliacs (SI)

– Trochanters

PAIN

ROM – Flexes to	Most	More	Less	Much	Moderate	Little
Lists –						
Extension from flexion – normal, lag	Most	More	Less	Much	Moderate	Little
Extension –	Most	More	Less	Much	Moderate	Little
Rt. bend –	Most	More	Less	Much	Moderate	Little
Lt. bend –	Most	More	Less	Much	Moderate	Little
Rt. Rotation –	Most	More	Less	Much	Moderate	Little
Lt. Rotation –	Most	More	Less	Much	Moderate	Little

Neuro – Motor:

DTR's: Ankles –

Knees –

Sensory:

Proprioception:

Babinksi's:

Clonus

Atrophy – Thigh

Calf –

Pulses –

Edema –

Strength and pain:

Hip rotation –

Psoas –

SLR, Rt. –

Adductors –

Lt. –

Abductors –

Hamstring tightness

Hamstrings –

Bowstring, Rt. –

Quadriceps –

Lt. –

BASLR

Femoral Stretch

LLD –