



NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please read: This questionnaire has been designed to give the doctor information as to how your back pain has affected your life. Please answer **EVERY** question, and mark in each section only the **ONE** box that 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 I: PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad, but I manage without pain killers.
- Painkillers give me complete relief from pain.
- Painkillers give me moderate relief from pain.
- Painkillers give me very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

### SECTION II: PERSONAL CARE (washing, dressing, etc.)

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

### SECTION III: LIFTING

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

### SECTION IV: WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 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 stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.



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### SECTION V: SITTING

- I can sit in any 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.

### SECTION VI: 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 for more than 1 hour.
- Pain prevents me from standing for more than ½ hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### SECTION VII: SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only using tablets.
- Even when I take tablets, I have less than 6 hours sleep.
- Even when I take tablets, I have less than 4 hours sleep.
- Even when I take tablets, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### SECTION VIII: SEX LIFE

- My sex life is normal and causes no extra pain.
- My sex life is normal, but causes 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.

### SECTION IX: SOCIAL LIFE

- My social life is normal and gives me no extra pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant affect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- I have no social life because of pain.

### SECTION X: TRAVELING

- I can travel anywhere without extra 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 ½ hours.
- Pain prevents me from traveling, except to the doctor and hospital.



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**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please mark the areas on this body diagram where you feel the described sensations. Use the appropriate symbol. Mark any areas of radiation. Include *all* affected areas.

<b>Ache</b> <<<<<	<b>Numbness</b> ===	<b>Pins &amp; Needles</b> OOOOO	<b>Burning</b> xxxxx	<b>Stabbing</b> /////
<<<<<	===	OOOOO	xxxxx	/////

Pain in arm(s) compared to neck:  
Worse than: \_\_\_\_\_  
Same as: \_\_\_\_\_  
Less than: \_\_\_\_\_

Pain in leg(s) compared to back:  
Worse than: \_\_\_\_\_  
Same as: \_\_\_\_\_  
Less than: \_\_\_\_\_

**BACK**

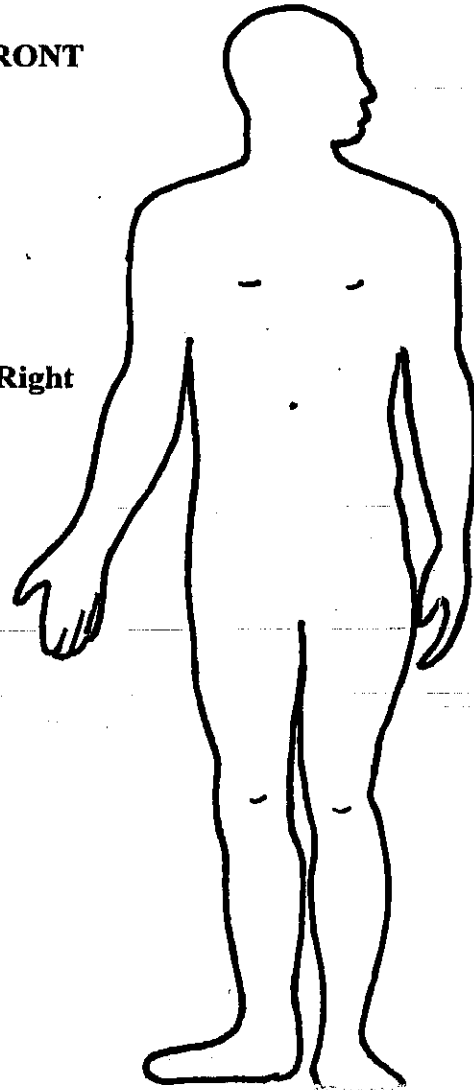
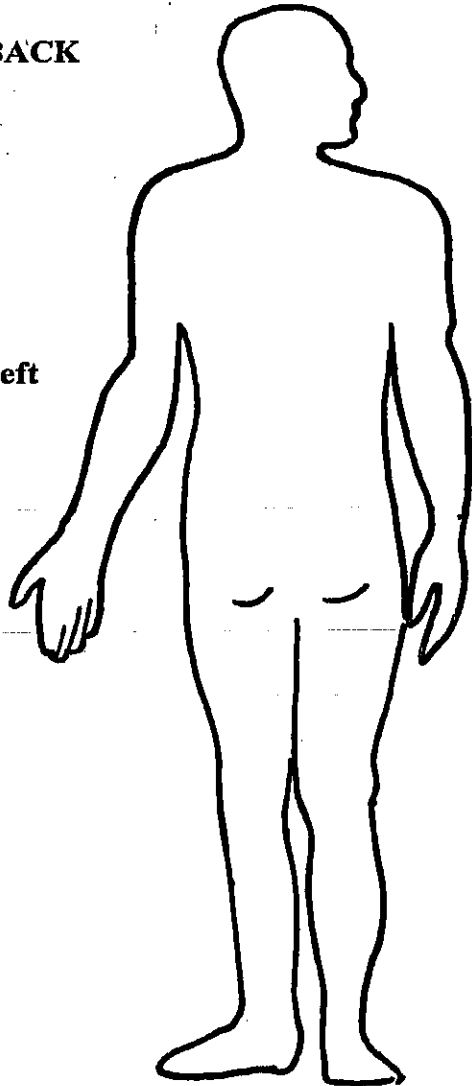
**FRONT**

**Left**

**Right**

**Right**

**Left**





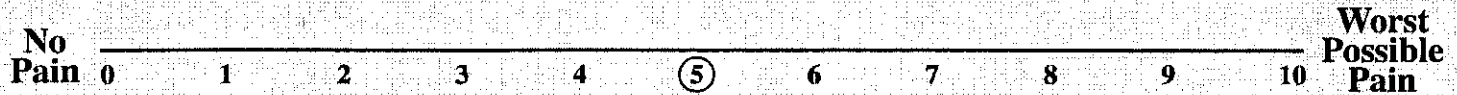
Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Please read carefully:

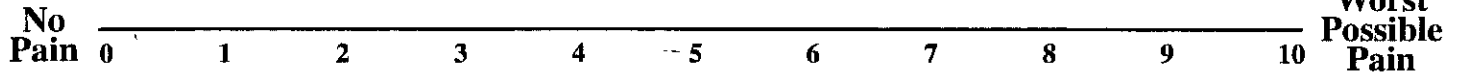
**Instructions: please circle the number that best describes the question being asked.**

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.

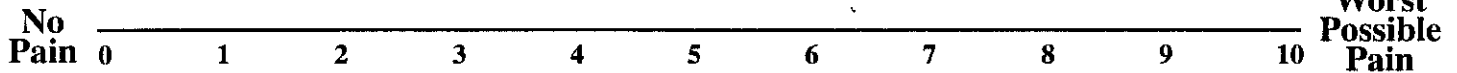
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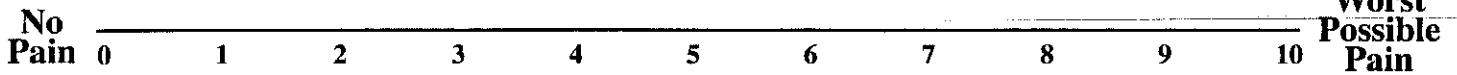
1. What is your pain RIGHT NOW?



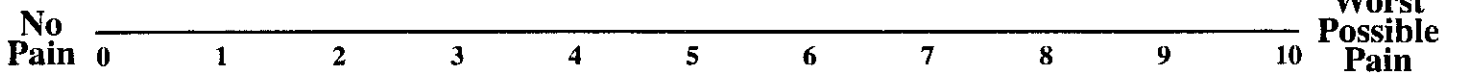
2. What is your TYPICAL or AVERAGE pain?



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 \_\_\_\_\_

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