STANDARD FORM: Primary complaint - Please circle: Low back / leg *OR* Neck / arm

NAME ______________________ DATE__________ BD ________ SC ______

1. Where do you have pain? Place a ✓ for all appropriate sites. (2x)

☐ neck ☐ shoulders ☐ upper back ☐ lower back ☐ leg

2. How long ago did your **current** episode begin? (2x)

1. ☐ **Less than two weeks ago** **2.** ☐ **2 weeks to <8 weeks ago**
3. ☐ **8 weeks to < 3 months ago** **4.** ☐ **Three months to < six months ago**
5. ☐ **>6 months ago**

3. How many **previous episodes** required treatment? (2x)

☐ None ☐ **1** ☐ **2** ☐ **3** ☐ **4 or more**

4. Have you been hospitalized or had surgery for the same or similar complaint before? **Yes / No**

5. Please indicate your usual level of pain during **the past week**:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

6. How **often** would you say that you have experienced pain episodes, on average during **the past 3 months**? (Circle one number)

Never 0 1 2 3 4 5 6 7 8 9 10 Always

7. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

8. During the last week, how often have you taken medication (such as aspirin, Motrin, Tylenol or prescription medication) for your pain complaint?

Not at all0 1 2 3 4 5 6 7 8 9 10 3 or more times a day

9. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

10. How anxious (eg. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

11. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during **the past week:**

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

12. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not depressed at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

NAME: ________________________

13. How would you rate your general health? (10-X)
Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

14. Do you smoke tobacco a pack a day or more? **Yes / No**

15. An increase in pain is an indication that I should stop what I am doing until the pain decreases. (10-X)
Completely agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

16. Physical activity makes my pain worse?
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

17. I can do light work for an hour? (10-X)
Can't do it because of pain problem 0 1 2 3 4 5 6 7 8 9 10 Can do it without pain being a problem

18. I can sleep at night (10-X)
Can't do it because of pain problem 0 1 2 3 4 5 6 7 8 9 10 Can do it without pain being a problem

19. How physically demanding is your job -include housework if not employed outside the home?
Not at all demanding 0 1 2 3 4 5 6 7 8 9 10 Very Demanding

20. Have you been disabled due to the same or similar pain/complaint in the last 12 months? **Y / N**

21. I should not do my normal work with my present pain.
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

If you are disabled from work, when did your disability start? Date________________

22. How well do you like your work? (10-x)
Not at all 0 1 2 3 4 5 6 7 8 9 10 Very much

23. What kind of trouble at work do you think you will have sitting or standing **6 weeks from now?**
No trouble 0 1 2 3 4 5 6 7 8 9 10 Extreme trouble

24. On a scale of 0 to 10, how certain are you that you will be working in **six months**?
Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

Please sign your name ______________________________________ Date ______________