TOWSON ORTHOPAEDIC ASSOCIATES

SCOLIOSIS AND SPINE CENTER OF MARYLAND

Towson Orthopaedic Associates

Spine Follow-Up Questionnaire

OFFICE USE ONLY
Patient Acct # _____
Provider # _____
BMI _____
Height _____ Weight _____
Blood Pressure

Please complete all four pages of this form in blue/black ink.

Name: _____ **Age:** _____ **Date:** _____

1. Reason for visit today

- ☐ Routine post operative follow-up visit (date of surgery _____)
- ☐ Review ordered test
- ☐ Evaluate progress of therapy/injection
- ☐ Discuss continuing problem
- ☐ Other _____

2. Please indicate on the line below how bad your pain is now.

No Pain _____ **Worst Possible Pain**
0 **10**

3. ☐ **Current problem unchanged from last visit on** _____ **(date).**
☐ **Current problem changed from last visit on** _____ **(date).**

Describe changes: _____
_____
_____

4. What medication(s) and how much (either prescription or over the counter) are you currently taking for this pain? _____
_____
Pharmacy: _____ **Number:** _____

5. How many sessions of physical therapy have you had since last visit? _____ ☐ **N/A**

6. How many injections have you had since last visit? _____ ☐ **N/A**

7. Medical History (including; illness, surgery, & medications) are:
☐ **Unchanged** ☐ **Changed from last visit on** _____ **(date).**
Describe Changes _____
_____

8. Are you currently working? ☐ **Yes** ☐ **No**

9. Check any allergies: ☐ **None** ☐ **Penicillin** ☐ **Sulfa** ☐ **Aspirin** ☐ **Morphine** ☐ **Demerol**
☐ **Codeine** ☐ **Arthritis Drugs** ☐ **Anesthesia Problems** ☐ **Latex Allergy**
☐ **Other (list)** _____

10. Do you smoke cigarettes now? ☐ **Yes** ☐ **No**
If yes, how much _____ **packs per day for** _____ **years**
If you smoked in the past, how long has it been since you stopped? _____

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Patient Acct #_____
Provider #_____

Towson Orthopaedic Associates

Spine Follow-Up Questionnaire

Oswestry Form

Please read: This questionnaire has been designed to give the provider information on how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one answer that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please check just one which most clearly describes your problem.

Section 1 - Pain Intensity

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

Section 2 - 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 some help every day in most aspects of selfcare.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without causing 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 a 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 4 - 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 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a stick/cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit still 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 an hour.
- ☐ Pain prevents me from sitting more than 1/2 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 extra pain
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ Pain does not prevent me from sleeping at all.
- ☐ I can sleep well only by 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 8 - 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 9 - Social Life

- ☐ My social life is normal and gives no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect 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.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 - Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I can manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short, necessary journeys of less than 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

This spine follow-up form was reviewed by _____ MD/NP/PA Date: _____

Account Number:

SCOLIOSIS AND SPINE CENTER OF MARYLAND

Scoliosis and Spine Center
SF-36

Patient Name: _____

This questionnaire asks for your views about your general health. This information will help keep track of how you are feeling and how well you are able to do your usual activities. For each of the following questions, please mark with an "X" in the one box that best describes your answer. Please do not skip any questions.

1. In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?

☐ Much better now than 1 year ago
☐ About the same as 1 year ago
☐ Much worse now than 1 year ago
☐ Somewhat better now than 1 year ago
☐ Somewhat worse now than 1 year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes Limited a lot	Yes Limited a little	No Not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate activities, such as moving a table, pushing A vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than one mile	☐	☐	☐
h. Walking several blocks	☐	☐	☐
i. Walking one block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. Cut down the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kind of work or other activities	☐	☐
d. Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐

5. During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious?)

	Yes	No
a Cut down on the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Didn't do work or other activities as carefully as usual	☐	☐

Account Number:

SCOLIOSIS AND SPINE CENTER OF MARYLAND

Scoliosis and Spine Center
SF-36

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much bodily pain have you had during the past 4 weeks?

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling:
How much of the time during the past 4 weeks

	All of Of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b. Have you been very nervous?	☐	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps?	☐	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐	☐
i. Do you feel tired?	☐	☐	☐	☐	☐	☐

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

11. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know	☐	☐	☐	☐	☐
c. I expect my health to get worse	☐	☐	☐	☐	☐
d. My health is excellent	☐	☐	☐	☐	☐

Patient Signature: _____ **Date:** _____