PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

LOW BACK PAIN AND LEG PAIN INFORMATION

A Service of PROLIANCE SURGEONS®

_____ Age _____ Birthdate _____ Gender ☐M ☐F

Last Name **First Name** **MI**

Occupation: _____ **Today's Date**_____

What is your MAIN concern? (Check all that apply)

- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Buttock Pain
- ☐ Thigh pain
- ☐ Leg pain

If you have leg pain, which is WORSE?

- ☐ I don't have leg pain
- ☐ Both legs hurt about EQUALLY
- ☐ Both, Right worse than Left
- ☐ Both, Left worse than Right
- ☐ Right leg pain ONLY
- ☐ Left leg pain ONLY

WHEN did this start? _____

What is worse? ☐ Back pain ☐ Leg pain ☐ EQUAL

What CAUSED this problem?

- ☐ I don't know
- ☐ A Fall
- ☐ Sports Injury
- ☐ Car Accident
- ☐ Lifting
- ☐ Other:_____

Did it start GRADUALLY or SUDDENLY?

- ☐ Gradually
- ☐ Suddenly

Is there pending legal action related to your pain / problem?

☐ No ☐ YES (explain): _____

Have you seen other doctors for this?

Who is your Primary Doctor?_____

If yes, list their names:

1) _____
2) _____
3) _____

What TESTS have you had done for this?

- ☐ X-rays
- ☐ Blood Tests
- ☐ MRI
- ☐ CT scan
- ☐ Bone Scan
- ☐ Discogram
- ☐ EMG
- ☐ Nerve block / ESI

What TREATMENT have you had for this?

- ☐ Nothing
- ☐ Rest
- ☐ Pain Medicine
- ☐ Muscle relaxant
- ☐ Anti-inflammatories
- ☐ Physical therapy
- ☐ Epidural steroid injection
- ☐ Prednisone
- ☐ Massage
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Other: _____

Do you exercise regularly? ☐ Yes ☐ No

If Yes what? _____

How many days a week? _____

CURRENT Symptoms:

Back pain ☐Yes ☐No

Buttock Pain ☐Right ☐Left

Leg pain ☐Right ☐Left

Numbness Where: _____

Tingling Where: _____

Leg Weakness Explain: _____

Bowel or bladder issue: Explain: _____

Pain with cough / sneeze ☐Yes ☐ No

Does pain wake you up ☐Yes ☐ No

Is your LEG pain or BACK pain worse?

☐Back pain WORSE than leg pain

☐Leg pain WORSE than back pain

☐Back pain about EQUAL to leg pain

Is your BACK pain ☐Aching ☐Burning ☐Stabbing ☐Sharp ☐Dull ☐Stiff ☐Pins and Needles

WHEN is your pain the worst ☐Morning ☐Evening ☐Night-time ☐Mid-day ☐All day/night

Is your LEG pain ☐Aching ☐Burning ☐Stabbing ☐Sharp ☐Dull ☐Stiff ☐Pins and Needles

WHEN is your pain the worst ☐Morning ☐Evening ☐Night-time ☐Mid-day ☐All day/night

What makes the pain WORSE?

☐Sitting ☐Standing

☐Lying down ☐Walking

☐Lifting ☐Exercise

☐Bending Forward ☐Working

☐Bending Backward

☐Other: _____

What makes the pain BETTER?

☐Sitting ☐Standing

☐Lying Down ☐Walking

☐Exercise

☐Pain Medicine ☐Anti-inflammatories

☐Massage ☐Ice / Heat

☐Other: _____

Do you have any of the following SYMPTOMS?

☐Feeling sick ☐Weight Loss ☐Fevers ☐Shaking Chills ☐Nausea ☐Morning Stiffness

Are you taking any medications for this now?

Medication name Pills per day

1) _____

2) _____

3) _____

4) _____

Recently are your symptoms?

☐Getting worse

☐ Staying about the same

☐Getting better

PREVIOUS Back Problems:

Have you had back problems before this? ☐Yes ☐No If YES, how many years ago did it start? _____

Have you had surgery ON YOUR BACK before? ☐Yes ☐No

If Yes please list the type of operation, approximate year, and Doctor's name

Operation **Year** **Doctor**

1) _____

2) _____

3) _____

Modified Oswestry Low Back Pain Disability Questionnaire

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today.
We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights 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 walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but it increases my 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 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex 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 my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

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

(office use) Score: _____