



Rocky Mountain  
 Orthopaedic Associates, P.C.  
 627 25½ Road  
 Grand Junction, CO 81505  
 Phone (970) 242-3535  
 1-800-856-9640  
 Fax (970) 242-0293

This questionnaire has been designed to help you to describe your pain and how it affects the management of your every day life. In order to adequately assess your case, we ask you to fill the form out yourself. Please be sure to read the instructions to each section carefully. Thank you for your patience.

**PLEASE USE BLACK OR BLUE PEN ONLY**

**Back Pain Questionnaire**

Today's Date: \_\_\_\_\_  
(Month) (Day) (Year)

\_\_\_\_ Miss Last Name: \_\_\_\_\_  
 \_\_\_\_ Ms. First Name: \_\_\_\_\_  
 \_\_\_\_ Mrs. Maiden Name: \_\_\_\_\_  
 \_\_\_\_ Mr. Initial: \_\_\_\_\_

Address

Tel. ( ) \_\_\_\_\_  
 \_\_\_\_\_  
(No.) (Street)  
 \_\_\_\_\_  
(Apt. No.) (City)  
 \_\_\_\_\_  
(State) (Country) (Zip)

Birth Date: \_\_\_\_\_  
(Month) (Day) (Year)

Insurance company: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Policy Number: \_\_\_\_\_

**Occupational Information:**

Occupation: \_\_\_\_\_  
 Unemployed: Yes \_\_\_\_\_ No \_\_\_\_\_

Is your income sufficient for your needs? Yes \_\_\_\_\_ No \_\_\_\_\_

Last grade of education completed? \_\_\_\_\_

Income Source

Spouse	Yes _____	No _____
Employer	Yes _____	No _____
Social Security	Yes _____	No _____
Disability	Yes _____	No _____
Unemployment	Yes _____	No _____
Worker's Compensation	Yes _____	No _____
Private Earnings	Yes _____	No _____
Other	Yes _____	No _____

What Doctor(s) have you seen about your Present Pain?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Which doctor referred you? \_\_\_\_\_

Family Physician: \_\_\_\_\_

Tel.( ) \_\_\_\_\_

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**Medical History**

Emphysema (asthma)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Night sweats	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you wear a shoe lift?
Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty sleeping	Yes <input type="checkbox"/> No <input type="checkbox"/>	No <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/>
Wheezing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever (recent)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty urinating	Yes <input type="checkbox"/> No <input type="checkbox"/>	Current medication including vitamins, laxatives, etc.
Gastritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Blood in stool	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, specify:</i> _____		
Appetite change	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Weight loss (unrelated to diet)	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Medical allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	List other past surgeries or injuries other than back surgery _____
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>If yes, specify:</i> _____		
Psoriasis	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Gout	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>			
<i>If yes, where?</i> _____				
		Antacids		
		Smoking Habit	Yes <input type="checkbox"/> No <input type="checkbox"/>	
		<i>Packs per day</i> _____		
Heart disease	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Hypertension (high blood pressure)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol Consumption:		
		_____ None		
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____ Occasional (1-2 drinks/day)		
Fatigue	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____ Heavy (5+ drinks/day)		
Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>			

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Is this a work accident? Yes  No   
 What was the date of your accident? \_\_\_\_\_  
 Onset of Pain \_\_\_\_\_  
 When did you stop working? \_\_\_\_\_  
 When did you return to work? \_\_\_\_\_  
 Do you have a file with Worker's Compensation?  
 Yes  No   
 If yes, your file number \_\_\_\_\_  
 How long have you been unable to work or do regular house work?  
 \_\_\_\_\_

How long have you had -  
 Back Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Buttock Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Leg Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Neck Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Arm Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Forearm Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Shoulder Pain Years \_\_\_\_\_ Months \_\_\_\_\_  
 Hand Pain Years \_\_\_\_\_ Months \_\_\_\_\_

If your job still available to you? Yes  No

If your work has been temporarily interrupted by your condition,  
 please indicate the days that you were unable to work:

From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_

Where was your Present pain initially located:

Low back  
 Low back and leg  
 Low back and then leg  
 Leg

Please describe your pain over recent weeks. Check one response  
 that best describes your condition.

No Pain  Mild Pain  
 Moderate; Requiring mild pain modification  
 (such as Aspirin or Tylenol)  
 Severe; Causing you to markedly modify your activities  
 and/or take (prescription) medication  
 Intense; So you can barely function  
 Excruciating; So that it is unbearable

Have you been admitted to hospital for low back pain or sciatica?  
 No  Yes  When? \_\_\_\_\_

Have you had a:

Facet Block	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
EMG	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Myelogram	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
CT scan	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Discogram	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Radiography	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Surgical procedures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Rhizolysis/Facet Rhysotomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Chemoneucleolysis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Spinal fusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Laminectomy/Discectomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Nerve block	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____ Year	_____ Month	_____ Day
Other: (Specify)					

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When do you have pain?

- A- All the time
- B- Only with certain activities
- C- A few days a week
- D- A few days a month
- E- Every few months
- F- Every few years
- G- Early morning
- H- Mid-day
- I- Later afternoon
- J- Evenings

Please check the ratio that best describes your pain.

- 100% back pain, 0% leg pain
- 75% back pain, 25% leg pain
- 50% back pain, 50% leg pain
- 25% back pain, 25% leg pain
- 0% back pain, 100% leg pain

Physical Activities

Are you physically active?  Yes  No

Which of these activities improve or worsen your pain?

- Jogging  Improve  Worsen
- Golfing  Improve  Worsen
- Aerobics  Improve  Worsen

How Did Your Pain Start, When Did You First Notice Your Pain?

(You may check more than one answer.)

- A- Unknown
- B- No accident
- C- Equal lifting (2 hands)
- D- Unequal lifting (2 hands) /unequal lifting (1 hand)
- E- Occurred while sitting
- F- Twisting
- G- Twisting while lifting
- H- Fall on side
- I- Fall on the buttocks
- J- Fall on the back
- K- Hit in back
- L- Auto accident
- M- Bending
- N- Pulling
- O- After back surgery
- P- Fall from a height
- Q- Walking
- R- Pregnancy
- S- Epidural block/ spinal anaesthesia
- T- Duration athletic activity
- U- Other (specify)

Please check the most appropriate response for each activity (And how it effects your present pain situation.)

	Better	Same	Worse		Better	Same	Worse
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Massage / manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Being upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The act of sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting for less than 15 mins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain killers (prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting for more than 30 mins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain killers (over the counter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shifting weight from one buttock to other, sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or anti-inflammatories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing up from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leaning forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending backwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking downhill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Walking uphill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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How would you describe your pain?  
 (You may check more than one answer.)

	Back	Leg
Numb	_____	_____
Pins and needles	_____	_____
Stabbing	_____	_____
Burning	_____	_____
Aching	_____	_____
Sharp	_____	_____
Shooting	_____	_____
Dull	_____	_____
Spasm type	_____	_____
Throbbing	_____	_____
Wrenching	_____	_____
Deep-seated	_____	_____
Pressing	_____	_____
Tingling	_____	_____
Like an electric current	_____	_____

Do you experience any of the following:

Pain in your whole leg	_____ Yes	_____ No
Numbness in your whole leg	_____ Yes	_____ No
Inability to tolerate (put up with treatment)	_____ Yes	_____ No
Feeling as if your whole leg may give way	_____ Yes	_____ No
Pain in the tail bone	_____ Yes	_____ No
Continuous pain (no pain free) spells?	_____ Yes	_____ No
Have you ever admitted to the hospital as an emergency back pain case?	_____ Yes	_____ No

How would you rate the intensity of your pain today?

Mild 1 2 3 4 5 6 7 8 9 10 Severe

(Please circle the number that corresponds to your pain.)

Did your pain begin: \_\_\_\_\_ Suddenly \_\_\_\_\_ Gradually \_\_\_\_\_ At work

Does walking bring about pain in your: Back \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Legs \_\_\_\_\_ Yes \_\_\_\_\_ No

How many blocks can you walk before the pain or weakness starts?  
 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 2 miles

Does your pain always occur after you have walked the same amount of distance? \_\_\_\_\_ Yes \_\_\_\_\_ No

My pain has become: \_\_\_\_\_ Worse \_\_\_\_\_ Improved \_\_\_\_\_ Remained Constant

My legs feel: \_\_\_\_\_ Cold \_\_\_\_\_ Warm \_\_\_\_\_ Same

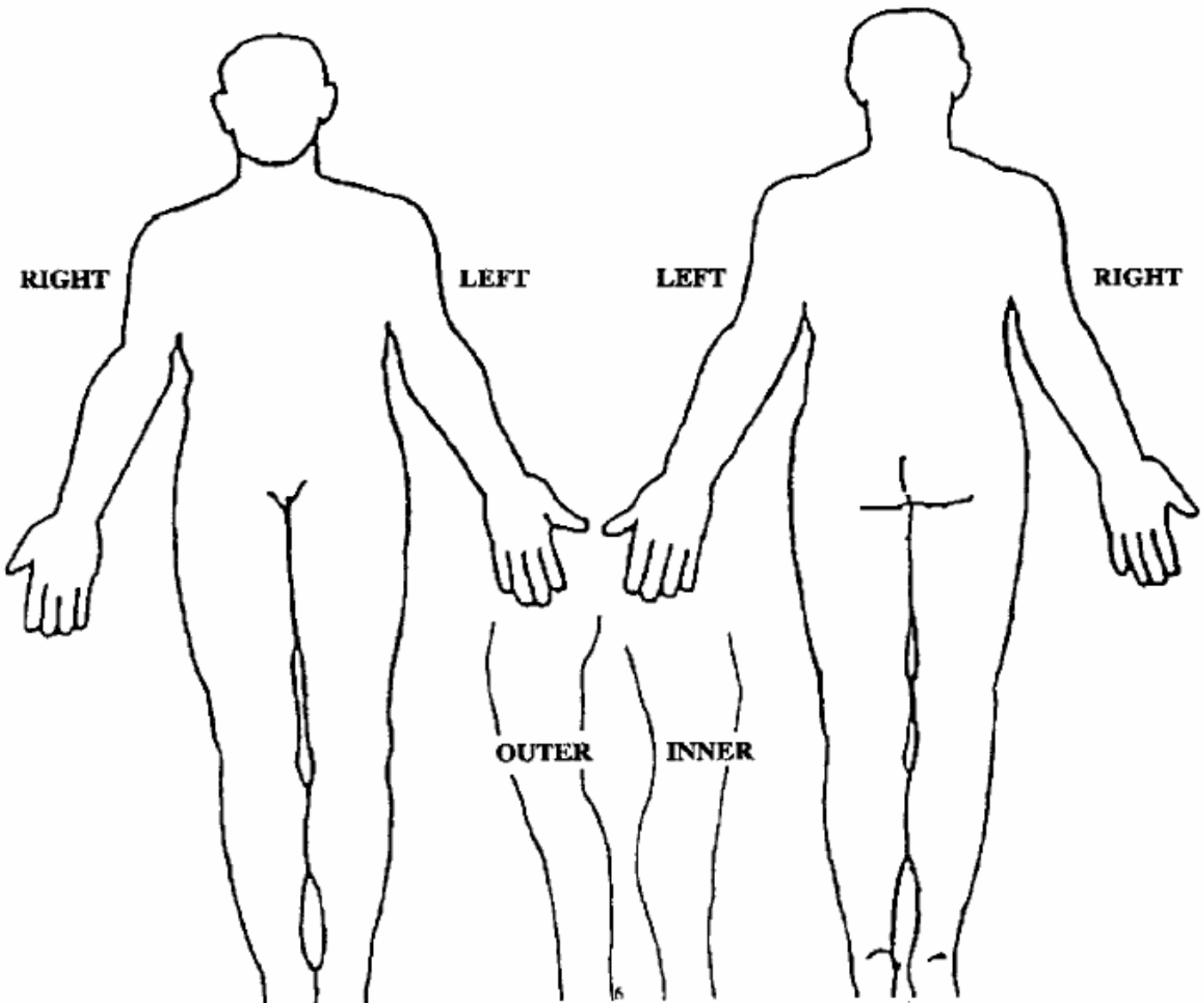
Do(es) your leg(s) feel: As if they are made of rubber. \_\_\_\_\_ Yes \_\_\_\_\_ No  
 As if they do not belong to you. \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Paralyzed. \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Weak. \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you: Have low back stiffness early in the morning? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Have "catches" in the low back when you roll in bed? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Wake up at night from sleep and feel that you must walk to obtain relief from back pain? \_\_\_\_\_ Yes \_\_\_\_\_ No

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Please mark the areas on your body where you feel your sensation. Be sure to use the appropriate symbol. Include all affected areas. Then color the symbols with the corresponding highlighter.

Numbness	Pins/needles	Burning	Stabbing/Sharp	Ache or Dull
===	ooo	xxx	///	vvv
===	ooo	xxx	///	vvv
===	ooo	xxx	///	vvv
GREEN	PINK	YELLOW	ORANGE	BLUE



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Please mark an x along the line to show your present pain situation.  
 Example:

How does bad weather affect your pain?

<b>NO PAIN</b>				<b>WORST POSSIBLE PAIN</b>
----------------	--	--	--	----------------------------

1. How bad is your pain?

<b>NO PAIN</b>				<b>WORST POSSIBLE PAIN</b>
----------------	--	--	--	----------------------------

2. How bad is the pain at night?

<b>NO PAIN</b>				<b>WORST POSSIBLE PAIN</b>
----------------	--	--	--	----------------------------

3. Does the pain interfere with your lifestyle?

<b>NO CHANGE</b>				<b>TOTAL CHANGE IN LIFESTYLE</b>
------------------	--	--	--	----------------------------------

4. How good are the painkillers for you?

<b>COMPLETE RELIEF</b>				<b>NO RELIEF</b>
------------------------	--	--	--	------------------

5. How stiff is your back?

<b>NO STIFFNESS</b>				<b>WORST POSSIBLE STIFFNESS</b>
---------------------	--	--	--	---------------------------------

6. Does your pain interfere with walking?

<b>NO PROBLEM</b>				<b>CANNOT WALK AT ALL</b>
-------------------	--	--	--	---------------------------

7. Do you hurt when walking?

<b>NO PAIN</b>				<b>WORST POSSIBLE PAIN</b>
----------------	--	--	--	----------------------------

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8. Does your pain keep you from standing still?

<b>I CAN STAND AS LONG AS I WANT</b>				<b>I CAN'T STAND AT ALL</b>
--------------------------------------	--	--	--	-----------------------------

9. Does your pain keep you from twisting?

<b>NO PROBLEM</b>				<b>CANNOT TWIST</b>
-------------------	--	--	--	---------------------

10. Does your pain allow you to sit in an upright hard chair?

<b>I CAN SIT AS LONG AS I LIKE</b>				<b>CAN'T SIT ON A HARD CHAIR</b>
------------------------------------	--	--	--	----------------------------------

11. Does your pain allow you to sit in a soft chair?

<b>I CAN SIT AS LONG AS I LIKE</b>				<b>CAN'T SIT IN A SOFTCHAIR</b>
------------------------------------	--	--	--	---------------------------------

12. Do you have back pain when lying in bed?

<b>NO PAIN</b>				<b>NO RELIEF AT ALL</b>
----------------	--	--	--	-------------------------

13. How much does your pain limit your normal lifestyle?

<b>NO LIMIT</b>				<b>CAN'T DO ANYTHING</b>
-----------------	--	--	--	--------------------------

14. Does your pain interfere with your work?

<b>NO PROBLEM</b>				<b>CANNOT WORK AT ALL</b>
-------------------	--	--	--	---------------------------

15. How often have you had to change your workplace because of back pain?  
 (If unemployed or retired, do you have to adjust everyday home activities?)

<b>NO CHANGE</b>				<b>VERY OFTEN I CAN'T KEEP A JOB</b>
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Do you find that, because of pain, you: (You may check [√] more than one if applicable.)

- \_\_\_\_\_ Can't sit for more than 30 minutes.
- \_\_\_\_\_ Can't travel for more than 30 minutes.
- \_\_\_\_\_ Can't stand for more than 30 minutes.
- \_\_\_\_\_ Can't walk for more than 30 minutes.
- \_\_\_\_\_ Can't do any heavy lifting.
- \_\_\_\_\_ Need help to put on my footwear.
- \_\_\_\_\_ Have a disturbed sleep.
- \_\_\_\_\_ Have a restricted social life.
- \_\_\_\_\_ Have a restricted sex life.

Please check [√] only one answer that best and most closely describes your problem.  
Please answer every section.

Pain Intensity

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

Personal Care (washing, bathing, dressing)

- \_\_\_\_\_ 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.

Lifting

- \_\_\_\_\_ I can lift heavy weight without extra pain.
- \_\_\_\_\_ I can lift extra weight but it causes extra pain.
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off the floor,  
but I can manage if they are conveniently positioned on a table.
- \_\_\_\_\_ Pain prevents me from lifting heavy weights off the floor,  
but I can manage light to medium weights if they are conveniently positioned.
- \_\_\_\_\_ I can lift only very light weights.
- \_\_\_\_\_ I can't lift or carry anything at all.

Walking

- \_\_\_\_\_ Pain does not prevent me from walking any distance.
- \_\_\_\_\_ Pain prevents me from walking more than 1 mile (20 minutes non-stop).
- \_\_\_\_\_ Pain prevents me from walking more than ½ mile (10 minutes non-stop).
- \_\_\_\_\_ Pain prevents me from walking more than ¼ mile (5 minutes non-stop).
- \_\_\_\_\_ I can only walk using a cane or crutches.
- \_\_\_\_\_ I am in bed most of the time and have to crawl to the toilet.

Sitting Position

- \_\_\_\_\_ I am able to sit in any seat for as long as I wish.
- \_\_\_\_\_ I am able to sit for as long as I wish only in my favorite seat.
- \_\_\_\_\_ Pain prevents me from sitting for longer than 1 hour.
- \_\_\_\_\_ Pain prevents me from sitting for longer than 30 minutes.
- \_\_\_\_\_ Pain prevents me from sitting for longer than 10 minutes.
- \_\_\_\_\_ Pain prevents me from sitting.

Standing

- \_\_\_\_\_ I am able to stand for as long as I wish without causing extra pain.
- \_\_\_\_\_ I am able to stand for as long as I wish but it causes extra pain.
- \_\_\_\_\_ Pain prevents me from standing for longer than 1 hour.
- \_\_\_\_\_ Pain prevents me from standing for longer than 30 minutes.
- \_\_\_\_\_ Pain prevents me from standing for longer than 10 minutes.
- \_\_\_\_\_ Pain prevents me from standing.

Sleeping

- \_\_\_\_\_ Pain does not prevent me from sleeping well.
- \_\_\_\_\_ 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.

Sex Life

- \_\_\_\_\_ I am not sexually active.
- \_\_\_\_\_ 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.

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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 effect on my social life apart from restricting my more energetic interests (dancing, certain sports).
- \_\_\_\_\_ Pain has restricted my social life and I do not go out often.
- \_\_\_\_\_ Pain has restricted my social life to my home.
- \_\_\_\_\_ I have no social life because of pain.

Travelling

- \_\_\_\_\_ 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 30 minutes.
- \_\_\_\_\_ Pain restricts me from travelling except to the hospital.

Please Indicate The Intensity of Your Pain By Marking a Small Vertical Line on the Pain Scale.  
Please Make the Line at the Point Where Your Present Level of Pain is Situated.

No Pain.....Intolerable Pain  
Mark Your Pain Estimate

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Please mark an x along the line that expresses your situation on the scale from 0% to 100% for each question.

For example: I feel good

	SOME					
<b>0% NEVER</b>						<b>100% MOSTLY ALL THE TIME</b>

SECTION 1:

1. To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

	SOME					
<b>0% NONE</b>						<b>100% ALL THE TIME</b>

2. How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing etc.)

	SOME					
<b>0% NONE</b>						<b>100% I CAN'T GET OUT OF BED</b>

3. How much limitation do you notice lifting?

	SOME					
<b>0% NONE I CAN LIFT AS BEFORE</b>						<b>100% I CAN'T LIFT ANYTHING</b>

4. Compared to how far you would walk before your injury or back trouble, how much does your pain restrict your walking now?

	ALMOST THE SAME			VERY LITTLE			
<b>0% I CAN WALK THE SAME</b>							<b>100% I CANNOT WALK</b>

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5. Back pain limits my sitting in a chair to:

SOME

<b>0% NO PAIN SAME AS BEFORE</b>							<b>100% I CANNOT SIT AT ALL</b>
--	--	--	--	--	--	--	-------------------------------------

6. How much does your pain interfere with your tolerance to stand for long periods?

SOME

<b>0% NONE SAME AS BEFORE</b>							<b>100% I CANNOT STAND</b>
---------------------------------------	--	--	--	--	--	--	----------------------------

7. How much does your pain interfere with your sleeping?

SOME

<b>0% NONE SAME AS BEFORE</b>							<b>100% I CANNOT SLEEP AT ALL</b>
---------------------------------------	--	--	--	--	--	--	---------------------------------------

SECTION 2:

8. How much does pain interfere with your social life (dancing, games, going out, eating with friends)?

SOME

<b>0% NONE SAME AS BEFORE</b>							<b>100% NO ACTIVITIES TOTAL LOSS</b>
---------------------------------------	--	--	--	--	--	--	--

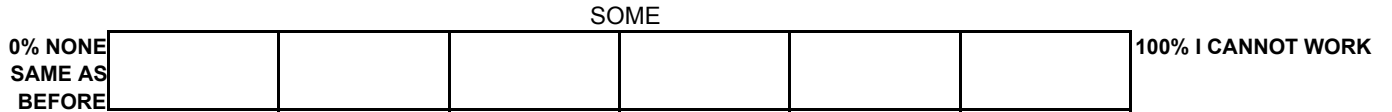
9. How much does pain interfere with travelling in a car?

SOME

<b>0% NONE SAME AS BEFORE</b>							<b>100% I CANNOT TRAVEL</b>
---------------------------------------	--	--	--	--	--	--	-----------------------------

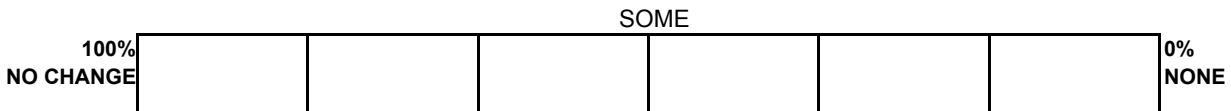
Rocky Mountain  
Orthopaedic Associates, P.C.  
 627 25½ Road  
 Grand Junction, CO 81505  
 Phone (970) 242-3535  
 1-800-856-9640  
 Fax (970) 242-0293

10. How much does pain interfere with your job? Job also means for retired: Lifestyle changes.



SECTION 3:

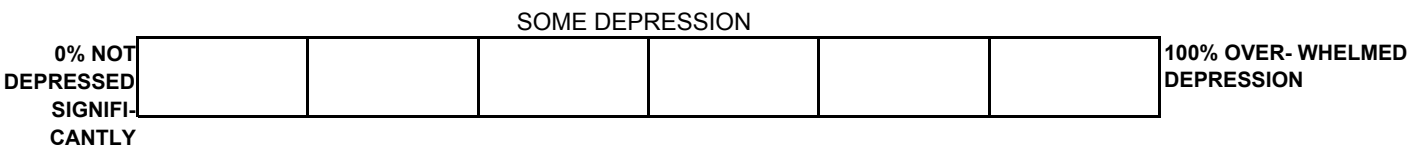
11. How much control do you feel that you have over demands made on you?



12. How much control do you feel that you have over your emotions?



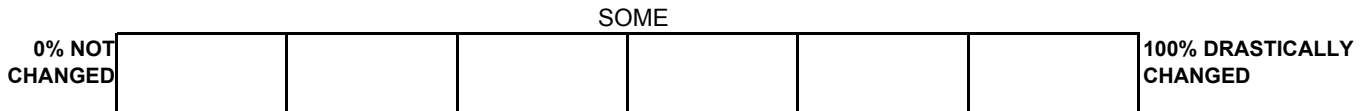
13. How depressed have you been since the onset of pain?



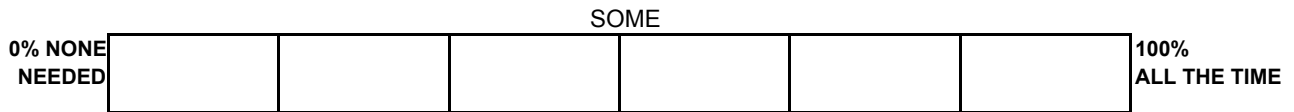
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SECTION 4:

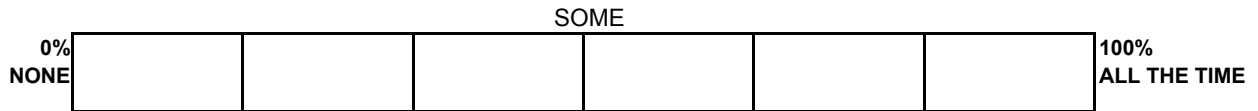
14. How much do you think your pain changed your relationship with others?



15. How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals)?



16. How much do you think others express irritations, frustration or anger toward you because of your pain?



Thank You for Helping Us to Help You