Name:_____ Today's Date:_____

CURRENT MEDICATIONS:

Please list prescription, non-prescription, vitamins, herbs, & other health supplements and days, weeks, or months taken.

Name **Dosage** **Frequency** **Duration of Treatment**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RECENT DOCTOR VISITS: When was the last time you saw a doctor & why?

Date of last Physical:_____ Date of last Lab Test:_____

Results:_____

Women: Date of last PAP smear:_____ Results:_____ Pregnant: Yes No Maybe

Men: Date of last PSA/Prostate test:_____

MEDICAL PROCEDURES, HOSPITALIZATIONS, INJURIES, SERIOUS ILLNESSES

Please list dates & outcomes of any of the above

Name **Procedure/Surgery/Illness** **Physician**

_____

_____

_____

_____

DIET: Do you follow any particular program or style of eating? (ex: Adkins, Low Fat, Vegetarian, etc.)

_____

EXERCISE: Do you exercise regularly? What is your program? _____

_____

If unable to exercise, what is stopping you? _____

HABITS/LIFESTYLE:

Please check any of the following that you use:

☐ tobacco ☐ alcohol ☐ black tea ☐ carbonated beverages ☐ aspirin

☐ Tylenol ☐ Advil ☐ antacids ☐ recreational drugs

other:

PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____ Date: _____

Instructions: These questions ask your views about how your pain affects how you function in every day activities. Please answer every question & mark **one number** on **each** scale that best describes how you feel.

1. Does your pain interfere with your normal work inside & outside the house?

Work normally — Unable to work at all

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all care

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

3. Does your pain interfere with your traveling?

Travel anywhere — Only travel to see doctors

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

4. Does your pain affect your ability to sit or stand?

No problem — Cannot sit/stand at all

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problem — Cannot do at all

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problem — Cannot do at all

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

7. Does your pain affect your ability to walk or run?

No problem — Cannot walk/run at all

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

11. Does your pain interfere with your ability to see the people that are important to you?

No problem — Never see them

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

12. Does your pain interfere with recreational activities & hobbies that are important to you?

No interference — Total interference

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

13. Do you need the help of your family/friend to complete everyday tasks (housework, etc.)?

Never need help — Need help always

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

14. Do you now feel more depressed, tense or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

15. Are there emotional problems from your pain that interfere with your family/social/work activities?

No problem — Severe problem

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Examiner_____

Other Comments:

With permission from: Anagnostics C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

Please rate the severity of your pain by circling a number below:

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

HEALTH APPRAISAL - BRIEF

NAME_____ DATE_____

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points_____

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/or vomiting	0	1	2	3
7. Specific foods/beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points_____

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections, difficulty breathing	0	1	2	3
8. Experience relief from carbonated beverages, cream/milk/food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points_____

Section D

1. Lower abdominal pain, cramping and/or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult,straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points_____

PART II

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3
12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points_____

Section B

1. Fatigue, sluggish	0	1	2	3
2. Feel cold, (i.e. hands and feet)	0	1	2	3

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Section B (continued)

3. Difficult, infrequent bowel movements	0	1	2	3
4. Dryness - skin, hair	0	1	2	3
5. Thick, brittle nails	0	1	2	3
6. Outer third of eyebrow thins	0	1	2	3
7. Puffy face, hands and feet	0	1	2	3
8. Swollen upper eyelids	0	1	2	3
9. Eyeballs move involuntarily	0	1	2	3
10. Muscles weak, cramp and/or tremble	0	1	2	3
11. Slow mental processes, forgetfulness	0	1	2	3
12. Slow heart beats	0	1	2	3
13. Loss of appetite	0	1	2	3
14. Abdominal swelling	0	1	2	3
15. Unsteady gait, movements	0	1	2	3
16. Lack of interest in sex	0	1	2	3
17. Premenstrual tension	N			Y (3)
18. Infertility	N			Y (3)
19. Heavy menstrual bleeding	N			Y (3)
20. Gain weight easily	N			Y (10)
21. Swelling of the neck	N			Y (10)
22. Thinning hair on scalp, face and genitals	N			Y (3)

Total Points_____

PART III

1. Progressive, mild fatigue after exertion or stress	0	1	2	3
2. General weakness	0	1	2	3
3. Blurred vision, dizzy when rising	0	1	2	3
4. Depression	0	1	2	3
5. Rapid mood swings	0	1	2	3
6. Irritable, nervous	0	1	2	3
7. Dark circles under the eyes	0	1	2	3
8. Disinterest in food	0	1	2	3
9. Abdominal pain	0	1	2	3
10. Indigestion	0	1	2	3
11. Blotchy skin (white patches)	0	1	2	3
12. Tan skin, no sun	0	1	2	3
13. Black freckles on upper forehead, face, neck	0	1	2	3
14. Craving for salty foods	0	1	2	3
15. Gradual loss of body hair	N			Y (3)
16. Sensitive to subtle changes in surroundings, weather	N			Y (5)

Total Points_____

PART IV

Section A

1. Generalized bone tenderness and achiness	0	1	2	3
2. Localized bone pain	0	1	2	3
3. Bone deformity or swelling	0	1	2	3
4. Shins hurt during or after exercises	0	1	2	3
5. Low back or hip pain	0	1	2	3
6. Limp, walking difficulties	0	1	2	3
7. Crunching or creaking sounds when move joints	0	1	2	3
8. Hands, feet, throat spasm, feel numb	0	1	2	3
9. Joint pain and stiffness - especially in spine, hips, knees	0	1	2	3
10. Hearing loss, headaches, ringing in ears	0	1	2	3
11. Established bone loss	N			Y (10)
12. Calcium deposits	N			Y (5)
13. Spinal curvature	N			Y (10)
14. Recent loss of height	N			Y (10)
15. Bow legs	N			Y (5)
16. Stooped posture	N			Y (5)
17. Hump at base of neck	N			Y (5)
18. Unexplained bone fracture	N			Y (10)
19. Tooth loss, gum disease	N			Y (3)

Total Points_____

Section B

1. General muscle ache, pains	0	1	2	3
2. Localized muscle stiffness, tension, pain	0	1	2	3
3. Specific points on body feel sore when presses	0	1	2	3
4. Headaches	0	1	2	3
5. Fatigue, tired, sluggish	0	1	2	3
6. Difficulty sleeping	0	1	2	3
7. Feel unrefreshed upon awakening	0	1	2	3
8. Muscle weakness or loss	0	1	2	3
9. Difficulty speaking swallowing	0	1	2	3
10. Muscle cramps or spasm	0	1	2	3
11. Muscles twitch or tremble - eyelids, thumb, calf muscle	0	1	2	3
12. Irresistible urge to move legs	0	1	2	3

Section B (continued)

13. Legs move during sleep	0	1	2	3
14. Numbing, tingling sensation	0	1	2	3
15. Excessive joint mobility	0	1	2	3
16. Unable to fully straighten or extend legs and/or arms	0	1	2	3
17. Upper or lower back pain	0	1	2	3

Total Points_____

Section C

1. Joint stiffness, soreness	0	1	2	3
2. Red, swollen painful joints	0	1	2	3
3. Joint stiffness worsens with rest, improves with moving	0	1	2	3
4. Cracking joints	0	1	2	3
5. Shooting, aching, tingling pain down the back of leg	0	1	2	3
6. Joint pain involves one or a few joints	0	1	2	3
7. Joints hurt when moving or when carrying weight	0	1	2	3
8. Limited range of motion	0	1	2	3
9. Difficulty standing up from sitting position	0	1	2	3
10. Joint stiffness improves with rest, worsens with moving	0	1	2	3
11. Headache	0	1	2	3
12. Difficulty chewing food or opening mouth	0	1	2	3
13. Numbness, prickling, tingling sensation in the neck, shoulder and arms	0	1	2	3
14. Involuntary muscle spasms	0	1	2	3
15. Deliberate movement with hands is difficult	0	1	2	3
16. Injure, strain, sprain easily	0	1	2	3
17. Discomfort or pain in neck, shoulder or arm	0	1	2	3
18. Knobby overgrowths on the joints closest to the fingertips	N			Y (5)
19. Double jointed	N			Y (5)
20. One leg shorter than the other	N			Y (5)

Total Points_____