

OADC NECK AND BACK QUESTIONNAIRE

Patient's Name: _____ D.O.B.: _____
 Age: _____ Acct#: _____
 Referring MD _____

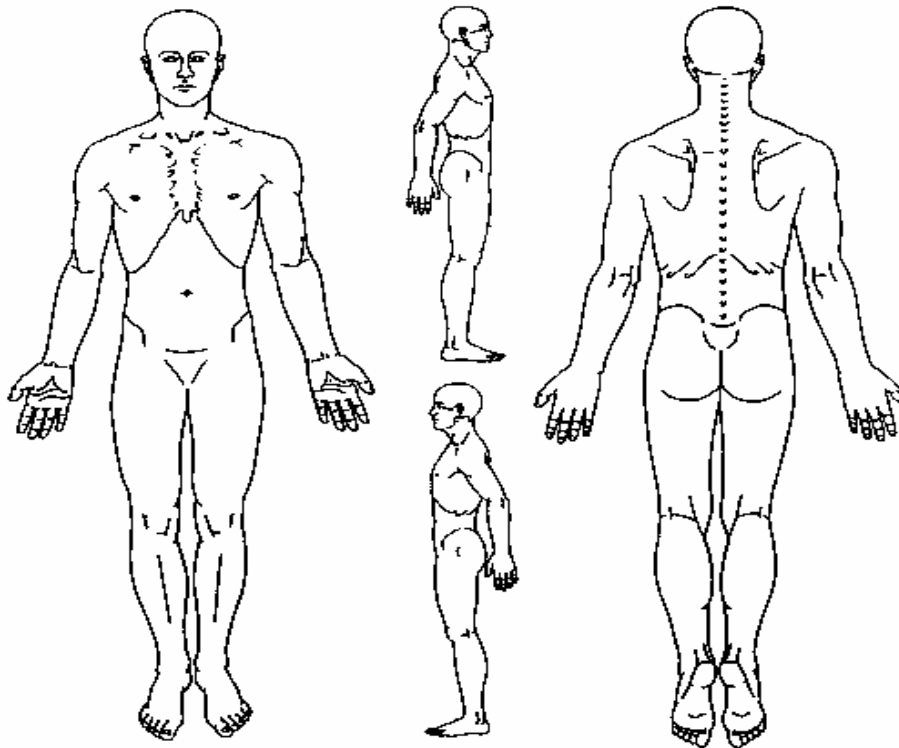
Please complete ALL of the following questions

1. Mark these drawings using the symbol that best describes your pain.

Numbness =====
Stabbing /////
 =====

Ache ^ ^ ^ ^ ^
Burning x x x x x

Pins and needles o o o o o
Cramping + + + + +



2. Which hurts you more, your legs or back? (check only one)

- ___ 1. Legs hurt much more than back
- ___ 2. Legs hurt somewhat more than back
- ___ 3. Legs and back hurt about the same
- ___ 4. Back hurts somewhat more than legs
- ___ 5. Back hurts much more than legs

3. Which hurts you more, your neck or arms? (check only one)

- ___ 1. Arms hurt somewhat more
- ___ 2. Arms hurt much more
- ___ 3. Neck hurts much more than arms
- ___ 4. Neck hurts somewhat more than arms
- ___ 5. Neck and arms hurt about the same

4. Please circle the number which best describes your current pain level.

0 represents no pain 10 is the worst pain you can imagine
 0 1 2 3 4 5 6 7 8 9 10

IF YOU HAVE BACK PROBLEMS

5. In the past week how often have you suffered from the following:
 (circle one number in response to each of the following questions)

	None of the time	A little of the time	Some of the time	A good bit of time	Most of the time	All of the time
Low back pain including buttocks	1	2	3	4	5	6
Leg pain	1	2	3	4	5	6
Numbness/tingling in the leg and/or foot	1	2	3	4	5	6
Weakness in leg and/or foot (ex. diff. Lifting foot)	1	2	3	4	5	6

6. In the past few weeks how bothersome have these symptoms been:
 (circle one number in response to each of the following questions)

	Not at all	Slightly	Somewhat	Very	Extremely
Low back pain including buttocks	1	2	3	4	5
Leg pain	1	2	3	4	5
Numbness/tingling in the leg and/or foot	1	2	3	4	5
Weakness in leg and/or Foot (ex. diff. Lifting foot)	1	2	3	4	5

IF YOU HAVE NECK PROBLEMS

7. In the past week how often have you suffered:
 (circle one number in response to each of the following questions)

	None of the time	A little of the time	Some of the time	A good bit of time	Most of the time	All of the time
Neck pain	1	2	3	4	5	6
Arm pain	1	2	3	4	5	6
Numbness or tingling in arm or hand	1	2	3	4	5	6
Weakness in arm and/or hand	1	2	3	4	5	6

8. In the past week, how bothersome have these symptoms been:

(circle one number in response to each of the following questions)

	Not at all	Slightly	Somewhat	Very	Extremely
Neck pain	1	2	3	4	5
Arm pain	1	2	3	4	5
Numbness/tingling in arm or hand	1	2	3	4	5
Weakness in arm and/or hand	1	2	3	4	5

9. During the last week, how frequently have you been taking:

(circle one number in response to each of the following questions)

	3 or more times a day	Once or twice a day	Once every couple of days	Once a week	Not at all
Narcotic medication for your spine pain (such as Codeine, Percodan, Vicoden)	1	2	3	4	5
Non-narcotic medication (such as Motrin, Tylenol, aspirin)	1	2	3	4	5
Muscle relaxers (such as Valium, Ativan, Meprobamate)	1	2	3	4	5

10. How long ago did your current episode begin?

- 1. Less than two weeks ago
- 2. Two weeks to less than eight weeks ago
- 3. Eight weeks to less than three months ago
- 4. Three months to less than six months ago
- 5. Six to twelve months ago
- 6. More than twelve months ago

11. How did your current episode begin:

- 1. Suddenly
- 2. Gradually

Please tell us how pain has affected your ability to perform the following daily activities during the last week, marking the one statement that best describes your average ability.

12. Dressing (in the last week)

- 1. I can usually dress myself without pain
- 2. I can dress myself without increasing pain
- 3. I can dress myself but pain increases
- 4. I can dress myself but have significant pain
- 5. I cannot dress myself

13. Lifting (in the last week)

- 1. I can lift heavy objects without pain
- 2. I can lift heavy objects but it is painful
- 3. Pain prevents me from lifting heavy objects off the floor but I can manage if they are on a table.
- 4. Pain prevents me from lifting heavy objects off the floor but I can manage light to medium objects if they are on a table
- 5. I can only lift light objects
- 6. I cannot lift anything

14. Walking (in the last week)

- 1. Pain doesn't prevent me from walking
- 2. Pain prevents me from walking more than one hour
- 3. Pain prevents me from walking more than 30 minutes
- 4. Pain prevents me from walking more than 10 minutes
- 5. I can only walk a few steps at a time
- 6. I am unable to walk

15. Sitting (in the last week)

- 1. I can sit in any chair as long as I like
- 2. I can only sit in a special chair for as long as I like
- 3. Pain prevents me from sitting more than one hour
- 4. Pain prevents me from sitting more than 30 minutes
- 5. Pain prevents me from sitting more than a few minutes
- 6. Pain prevents me from sitting at all

16. Standing (in the last week)

- 1. I can stand as long as I want
- 2. I can stand as long as I want but it gives me pain
- 3. Pain prevents me from standing for more than one hour
- 4. Pain prevents me from standing for more than 30 minutes
- 5. Pain prevents me from standing for more than 10 minutes
- 6. Pain prevents me from standing at all

17. Sleeping (in the last week)

- 1. I sleep well
- 2. Pain occasionally interrupts my sleep
- 3. Pain interrupts my sleep half of the time
- 4. Pain often interrupts my sleep
- 5. Pain always interrupts my sleep
- 6. I never sleep well

18. Social and recreational life (in the last week)

- 1. My social and recreational life is unchanged
- 2. My social and recreational life is unchanged but it increases pain
- 3. My social and recreational life is unchanged but it severely increases pain
- 4. Pain has restricted my social and recreational life
- 5. Pain has severely restricted my social and recreational life
- 6. I have essentially no social or recreational life because of pain

19. Traveling (in the last week)

- 1. I can travel anywhere
- 2. I can travel anywhere but it gives me pain
- 3. Pain is bad but I can manage to travel over 2 hours
- 4. Pain restricts me to trips of less than 1 hour
- 5. Pain prevents me from traveling

20. Sex life (in the last week)

- 1. My sex life is unchanged
- 2. My sex life is unchanged but causes me some extra pain
- 3. My sex life is nearly unchanged but is very painful
- 4. My sex life is severely restricted by pain
- 5. My sex life is nearly absent because of pain
- 6. Pain prevents any sex life at all

21. How often do you need to use the following assistive devices (in the last week)

	Never	Sometimes	About half the time	Often	All of time
One or two canes	1	2	3	4	5
One or two crutches	1	2	3	4	5
Walker	1	2	3	4	5
Wheelchair	1	2	3	4	5

**22. Has there been any change in your medical condition (not spine related) in the past six months?
If yes, please describe.**

23. Have you had a prior injury or problem with the condition you are being seen for? If yes, please describe.

TREATMENT

**24. What health care providers have you used for your current back condition in the last month?
(mark all that apply)**

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Acupunturist | <input type="checkbox"/> Immediate care
clinic | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Chiroprator |
| <input type="checkbox"/> Internest | <input type="checkbox"/> Orthopedic
surgeon | <input type="checkbox"/> Emergency
room | <input type="checkbox"/> Massage
therapist |
| <input type="checkbox"/> Pain clinic | <input type="checkbox"/> Rheumatologist | <input type="checkbox"/> Work hardening
clinic | <input type="checkbox"/> Physical
Therapist |
| <input type="checkbox"/> General
Practitioner | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Other | <input type="checkbox"/> None of
the above |

25. Do you have any allergies to medications? If yes, please list.

26. Have you had any previous surgery or hospitalizations? If yes, please list.

27. If you are in Physical Therapy, Where? _____
Number of treatments since last spine care visit? _____

28. Please indicate whether you have had any of the following tests (check all that apply)

___ CT ___ MRI ___ Plain X-rays ___ EMG ___ Bone scan ___ None
Others: _____

29. Do you have a lawyer or is this/there litigation regarding your injury/illness?

The following questions are about how you feel and how things have been with you during the last week. For each question, please indicate the one answer that comes closest to how you feel. Please mark one on each line.

30. How much time during the last week:

(circle one number in response to each of the following questions)

	All of the time	Most of the time	A good bit of time	Some of the time	Little of the time	None of the time
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps, nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Have you felt down hearted and blue?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6

31. Did you have a happy childhood? ___ yes ___ no

32. Did you smoke cigarettes in the last month? (check only one)

- ___ 1. I have never smoked
___ 2. Yes
___ 3. No, I quit in the last 6 months
___ 4. No, I quit more than 6 months ago

33. Have you used alcoholic beverages (beer, wine, liquor) to relieve your current neck or back pain? (check only one)

- 1. No
- 2. Yes, once in a while
- 3. Yes, often

34. Do you now or have you had in the past an alcohol or drug problem?

- Yes No

35. Are you: Married Divorced Single Separated Widowed?

36. Are you or could you be pregnant? Yes No

37. Do you have children? Yes No

38. Do you have activities/hobbies? Yes No

If yes, which ones? _____

EMPLOYMENT SITUATION

39. Which statements describe your current employment situation? (check only one statement)

- 1. Currently working
- 2. On paid leave
- 3. On unpaid leave
- 4. Unemployment
- 5. Homemaker
- 6. Student
- 7. Retired (not due to health)
- 8. Disabled and/or retired because of my back problem
- 9. Disabled due to a health problem not related to my back
- 10. Other, please specify _____

40. If you are not working, how long has it been since you stopped? (check only one statement)

- 1. Less than one week ago
- 2. One week to less than three months ago
- 3. Three months to less than six months ago
- 4. Six to less than twelve months ago
- 5. One to two years ago
- 6. More than two years ago
- 7. Currently working
- 8. Never employed

41. Is your current job the same as you had when your current back symptoms started?
(check only one statement)

- 1. Yes, exact same job
- 2. Yes, but my job was modified or hours reduced because of my back
- 3. No, I have changed jobs because of my back symptoms
- 4. No, I have changed jobs but for reasons unrelated to my back
- 5. Not working now

42. Please answer the next 2 questions about your current job or the one you plan to go back to if on leave. (circle one number in response to each of the following questions)

	All of the time	Most of the time	A good bit of time	Some of the time	Little of the time	None of the time
How much sitting does your Work involve?	1	2	3	4	5	6
How much standing or walking does your work involve?	1	2	3	4	5	6
How often do you lift 25lbs on the job?	1	2	3	4	5	6
How often do you lift 50lbs on the job?	1	2	3	4	5	6

43. Circle one number in response to each of the following questions.

	Extremely	Very much	Quite a bit	Somewhat	A little	Not at all
Is your current work Physically demanding?	1	2	3	4	5	6
Is your work stressful to you?	1	2	3	4	5	6
How much do you like your co-workers?	1	2	3	4	5	6
How much do you like your supervisor?	1	2	3	4	5	6