



## OADC SPINE FOLLOW UP QUESTIONNAIRE

Patient's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Age: \_\_\_\_\_ Acct#: \_\_\_\_\_

Referring MD \_\_\_\_\_

1. 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

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

	<b>None of the time</b>	<b>A little of the time</b>	<b>Some of the time</b>	<b>A good bit of time</b>	<b>Most of the time</b>	<b>All of the time</b>
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

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

	<b>Not at all</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Very</b>	<b>Extremely</b>
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**

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

	<b>None of the time</b>	<b>A little of the time</b>	<b>Some of the time</b>	<b>A good bit of time</b>	<b>Most of the time</b>	<b>All of the time</b>
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

5. In the past week, how bothersome have these symptoms been:  
(circle one number in response to each of the following questions)

	<b>Not at all</b>	<b>Slightly</b>	<b>Somewhat</b>	<b>Very</b>	<b>Extremely</b>
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

6. During the last week, how frequently have you been taking:  
(circle one number in response to each of the following questions)

	<b>3 or more times a day</b>	<b>Once or twice a day</b>	<b>Once every couple of days</b>	<b>Once a week</b>	<b>Not at all</b>
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

**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.**

7. 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

**8. 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

**9. 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

**10. 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

**11. 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

**12. 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

**13. 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

## TREATMENT OUTCOMES

14. Right now, how important are the following treatment outcomes for you? (circle one number in response to each of the following questions)

	<b>Not imp.</b>	<b>Slightly imp.</b>	<b>Somewhat imp.</b>	<b>Very imp.</b>	<b>Extremely imp.</b>
Pain relief	1	2	3	4	5
To be able to do more everyday, household, or yard activities	1	2	3	4	5
To be able to sleep more comfortably	1	2	3	4	5
To be able to go back to my usual job	1	2	3	4	5
To be able to do more sports (biking, long walks)	1	2	3	4	5
Other (please describe) _____					

15. Indicate the result of the following treatments on your spinal problems. (circle one number in response to each of the questions)

	<b>Helpful</b>	<b>Not Helpful</b>	<b>Worse</b>	<b>Never Tried</b>
Hotpacks	1	2	3	4
Ice	1	2	3	4
Physical Therapy	1	2	3	4
Chiropractic	1	2	3	4
Acupuncture	1	2	3	4
Traction	1	2	3	4
Brace support	1	2	3	4
TENS	1	2	3	4
Epidural injection	1	2	3	4
Facet injection	1	2	3	4

16. If you had back pain, how has your back pain been affected by the treatment? (check only one statement)

- \_\_\_ 1. I did not have back pain to start with
- \_\_\_ 2. The pain is totally gone
- \_\_\_ 3. The pain is much better than before treatment
- \_\_\_ 4. The pain is somewhat better than before treatment
- \_\_\_ 5. The pain is about the same as before treatment
- \_\_\_ 6. The pain is somewhat worse than before treatment
- \_\_\_ 7. The pain is much worse than before treatment

**17.** If you had leg pain, how has your leg pain been affected by the treatment? (check only one statement)

- 1. I did not have leg pain to start with
- 2. The pain is totally gone
- 3. The pain is much better than before treatment
- 4. The pain is somewhat better than before treatment
- 5. The pain is about the same as before treatment
- 6. The pain is somewhat worse than before treatment
- 7. The pain is much worse than before treatment

**18.** If you had neck pain, how has your neck pain been affected by the treatment? (check only one statement)

- 1. I did not have neck pain to start with
- 2. The pain is totally gone
- 3. The pain is much better than before treatment
- 4. The pain is somewhat better than before treatment
- 5. The pain is about the same as before treatment
- 6. The pain is somewhat worse than before treatment
- 7. The pain is much worse than before treatment

**19.** If you had arm pain, how has your arm pain been affected by the treatment? (check only one statement)

- 1. I did not have arm pain to start with
- 2. The pain is totally gone
- 3. The pain is much better than before treatment
- 4. The pain is somewhat better than before treatment
- 5. The pain is about the same as before treatment
- 6. The pain is somewhat worse than before treatment
- 7. The pain is much worse than before treatment

**IF YOU HAD SPINE SURGERY**

**20.** After your most recent surgery, did you return to work?

- 1. No
- 2. Yes, with limitations
- 3. Yes, with no limitations
- 4. Never stopped working
- 5. Did not work:  A. Homemaker  C. Retired  
 B. Student  D. Other \_\_\_\_\_

**21.** After your most recent surgery, did you return to full function?

- No
- Yes

**22.** Has the treatment for your spine condition met your expectations so far? (check only one statement)

- 1. Yes, totally
- 2. Yes, almost totally
- 3. Yes, quite a bit
- 4. More or less
- 5. No, not quite
- 6. No, far from it
- 7. No, not at all

**23.** Would you have the same treatment again if you had the same condition? (check only one statement)

- 1. Definitely not
- 2. Probably not
- 3. Not sure
- 4. Probably yes
- 5. Definitely yes

**24.** If you had to spend the rest of your life with your spine condition as it is right now, how would you feel about it? (check only one statement)

- 1. Extremely dissatisfied
- 2. Very dissatisfied
- 3. Somewhat dissatisfied
- 4. Neutral
- 5. Somewhat satisfied
- 6. Extremely satisfied

**25.** How would you rate: (circle one number in response to each of the following questions)

	Excellent	Very Good	Good	Fair	Poor	Terrible
The information you were given about your back condition	1	2	3	4	5	6
the overall results of your treatment for back or leg pain	1	2	3	4	5	6
the overall results of your treatment for neck or arm pain	1	2	3	4	5	6

Thank you for your help. Please take a moment to go over the questionnaire to make sure that you have not missed any pages or questions.