

# RECONSTRUCTIVE ORTHOPEDICS

*The Expertise You Expect, The Compassion You Deserve*

## INITIAL PAIN QUESTIONNAIRE

Please complete this form prior to your first visit with your Reconstructive Orthopedics Spine Specialist

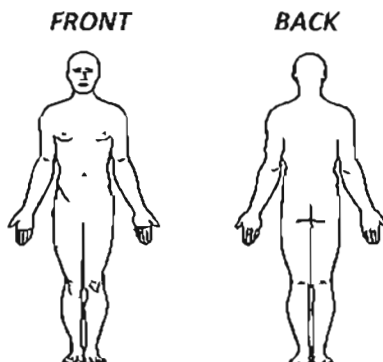
Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

What is the main problem for which you are seeking treatment? \_\_\_\_\_

Where is your pain located? \_\_\_\_\_

**Pain Location:** Please mark the location(s) of your pain on the diagrams with an "X". If entire areas are painful, please shade in these areas.



How long have you had this current pain problem? \_\_\_\_\_ Years \_\_\_\_\_ Months

How did your current pain start?

Injury at work                       Injury – not at work                       Motor vehicle accident  
 Undetermined                       Other (please describe): \_\_\_\_\_

In general, over the past month, the intensity of pain has been:

Mild                       Moderate                       Moderate-Severe                       Severe

- With 10 being the most severe, rate your pain from 0-10 \_\_\_\_\_
- With 10 meaning your pain greatly interferes with your activities of daily living and 0 meaning the pain does not interfere with activities of daily living, rate your pain from 0-10 \_\_\_\_\_

How often do you have pain? (Please mark one with an "X")

Constantly (100% of the time)                       Nearly constantly (60-95% of the time)  
 Intermittently (30-60% of the time)                       Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst: (Please mark one with an "X")

Morning                       Afternoon                       Evening                       Night                       No typical pattern

Please describe your pain: (Check all that apply)

Burning                       Sharp                       Pressure-like                       Cramping  
 Dull/Aching                       Throbbing                       Shooting                       Stabbing  
 Numbness                       Pins and Needles                       Other (describe): \_\_\_\_\_

Have you had weakness in your:

Upper extremities                       Lower extremities  
 Dropping objects                       Other (describe) \_\_\_\_\_

How do the following affect your pain? (Please check one for each item)

	DECREASE	NO CHANGE	INCREASE
Lying down			
Standing			
Sitting			
Walking			
Exercise			
Relaxation			
Coughing/Sneezing			
Bowel Movements			
Menstruation			
Bending forward			
Bending back			

Do you use a:     Cane     Walker     Wheelchair     No assistance device

Please list the names of the physicians you have seen for this pain problem and the year:

\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_

List all studies you have had for this problem: (X-rays, MRIs, EMG, CT Scans, Blood Tests, Myelograms)

Study: \_\_\_\_\_ Facility where taken: \_\_\_\_\_ Year: \_\_\_\_\_  
Study: \_\_\_\_\_ Facility where taken: \_\_\_\_\_ Year: \_\_\_\_\_  
Study: \_\_\_\_\_ Facility where taken: \_\_\_\_\_ Year: \_\_\_\_\_  
Study: \_\_\_\_\_ Facility where taken: \_\_\_\_\_ Year: \_\_\_\_\_

**PAIN TREATMENTS:** (Please check your response to all the treatments you have tried)

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Surgery			
Traction			
Nerve block/injection			
Physical Therapy			
Exercise			
TENS			
Heat/Ice Treatment			
Psychotherapy			
Acupuncture			
Hypnosis			
Biofeedback			
Chiropractic Manipulation			
Osteopathic Manipulation			

**PAIN MEDICATIONS:** (Please check all medication you have used for treatment of pain.)

<u>Opioids</u>	<u>Current</u>	<u>Past</u>	<u>NSAIDs/Tylenol</u>	<u>Current</u>	<u>Past</u>
Codine			Acetaminophen (Tylenol)		
Demerol			Asprin		
Fentanyl (Duragesic)			Celebrex		
Hydrocodone (Vicodin)			Ibuprofen		
Hydromorphone (Dilaudid)			Indocin		
Methadone			Lodine		
Morphine (MSContin)			Meloxicam (Mobic)		
Oxycodone (Percocet)			Nabumetone (Relafen)		
Oxycontin			Naproxen		
Oxymorphone (Opana)			Oxaprozin (Daypro)		
Propoxyphene (Darvocet)			Piroxicam (Feldene)		
Suboxone (Buprenorphine)			Salsalate/Trilisate		
Tramadol (Ultram)			Toradol		

<u>Other</u>	<u>Current</u>	<u>Past</u>	<u>Muscle Relaxants</u>	<u>Current</u>	<u>Past</u>
Amitriptyline (Elavil)			Alprazolm (Xanax)		
Duloxetine (Cymbalta)			Baclofen		
Nortriptyline (Pamelor)			Carisoprodol (Soma)		
Paroxetine (Paxil)			Cyclobenzaprine (Flexeril)		
Sertaline (Zoloft)			Diazepam (Valium)		
Venlafaxine (Effexor)			Lorazepam (Ativan)		
Carbamazepine (Tegretol)			Metaxalone (Skelaxin)		
Lyrica			Parafon Forte		
Topiramate (Topamax)			Robaxin		
Gabapentine (Neurontin)			Tizanidine (Zanaflex)		
Imitrex					
Klonopin					

<u>TOPICALS</u>	<u>CURRENT</u>	<u>PAST</u>	<u>TOPICAL CONT.</u>	<u>CURRENT</u>	<u>PAST</u>
Capsaicin			Voltaren Gel		
Diclofenac (Flector)			Lidocaine Patch		
Pennsaid					

**PAST MEDICAL HISTORY:** Have you had any of the following? (Please circle all that apply)

Alcoholism      Anxiety      Asthma or wheezing      Bleeding Problem      Chest Pain/Coronary Artery Disease

Depression      Diabetes      Emphysema      Fibromyalgia      GERD/Reflux Disease      Heart Attack  
 High Cholesterol      Hypertension      Psychiatric Problems      Seizure/ Epilepsy      Stomach Ulcers      Stroke  
 Thyroid Disease      Kidney Disease

Name of Psychiatrist / Therapist: \_\_\_\_\_

Arthritis (specify location): \_\_\_\_\_

Cancer (specify type): \_\_\_\_\_

Other (specify): \_\_\_\_\_

**PAST SURGICAL HISTORY:** List all surgeries you have had in the past and approximate date.

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

**ALLERGIES TO MEDICATIONS:** List the names of all medications to which you are allergic.

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____

\_\_\_\_ NO known drug allergies      Are you allergic to contrast dye used for x-rays? \_\_\_\_ YES      \_\_\_\_ NO

Are you allergic to latex? \_\_\_\_ YES      \_\_\_\_ NO      Are you allergic to shellfish \_\_\_\_ YES      \_\_\_\_ NO

**CURRENT MEDICATIONS YOU TAKE FOR PAIN:**

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Are these pain medications providing relief?**

\_\_\_\_ None of the time      \_\_\_\_ Some of the time      \_\_\_\_ Most of the time      \_\_\_\_ All of the time

**ALL OTHER CURRENT MEDICATIONS (OTHER THAN PAIN MEDICATION):**

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY:**

Employed full time      Employers Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employed part time      Current Occupation: \_\_\_\_\_  
 Unemployed       Retired       Student       Homemaker  
 Are you unemployed or employed part time due to your present pain condition?       YES       NO  
 Do you smoke?       YES       NO      How much nicotine per day? \_\_\_\_\_ Years? \_\_\_\_\_  
 Do you drink alcohol?       YES       NO       Beer       Wine       Liquor  
 Do you use recreational drugs? \_\_\_\_\_  
 Marital Status:       Married       Single       Widowed       Divorced       Separated  
 Do you live alone?       YES       NO      Who do you live with? \_\_\_\_\_  
 Are you pregnant?       YES       NO       N/A

**LEGAL ISSUES:** Please indicate any of the following claims you have filed related to your pain problems.

Workers Compensation       Social Security Disability Insurance  
 Personal Injury/Liability       Other Insurance

**FAMILY HISTORY:** Do you have a family history of the following?

	YES	NO		YES	NO
Back Disorder	YES	NO	Heart Disease	YES	NO
High Blood Pressure	YES	NO	Diabetes	YES	NO
Stroke	YES	NO	Thyroid Disease	YES	NO
Neuropathy	YES	NO	Cancer	YES	NO
Other: _____			If Yes, type of cancer		

**REVIEW OF SYSTEMS:**

Constitutional: Weight change, weakness, fatigue, fever  
 Eyes: Vision change, glasses, tearing, double vision  
 Ears, Nose, Mouth, Throat: Hearing change, tinnitus, vertigo, pain, sinusitis, sore gums, throat  
 Cardiovascular: Chest pain, palpitations, murmur, shortness of breath  
 Respiratory: cough, sputum, coughing up blood, wheezing, asthma, bronchitis, chest pain  
 Gastrointestinal: trouble swallowing, heartburn, vomiting, diarrhea, indigestion, pain, stool changes, blood in stool  
 Genitourinary: pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence  
 Musculoskeletal: joint pain/stiffness, cramps, back or neck ache, weakness, loss of range of motion  
 Skin: rash, lumps, itching, dryness, color change, hair changes, nail changes  
 Neurological: fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss  
 Psychological: nervousness, tension, mood changes, depression, anxiety  
 Endocrine: heat or cold intolerance, sweating, thirst, hunger, change in urination  
 Hematology/Lymphatics: bruising, bleeding, transfusion reactions  
 Allergies/Immunological: drug, product or other allergies; childhood immunizations

**PLEASE NOTE THAT WE DO NOT DETERMINE DISABILITY. IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE  
 48 HOURS PRIOR TO A MEDICATION REFILL. ALL PATIENTS ARE REQUIRED TO AGREE TO AND ABIDE BY THE  
 RECONSTRUCTIVE ORTHOPEDICS MEDICATION AGREEMENT/POLICY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

All other review of systems negative

ROS and PFSH reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
SIGNATURE OF PHYSICIAN

Updated: \_\_\_\_\_ Date: \_\_\_\_\_  
SIGNATURE OF PHYSICIAN

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any additional information you wish about the above answers.  
Thank you.

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Patient Name: _____ DOB: _____ Today's Date: _____
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## Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please check the one box that indicates the statement which most clearly describes your problem.

### Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

### Section 2: Personal Care (washing, 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 and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, was with difficulty and stay in bed

### Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently on the edge of a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

### Section 4: Walking

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ½ mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time

### Section 5: Sitting

- I can sit 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 one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

### Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

### Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours of sleep
- Because of pain I have less than 4 hours of sleep
- Because of pain I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

### Section 8: Sex Life (if applicable)

- 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

### Section 9: 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 limiting my more energetic interests like sports
- Pain has restricted my social life and I do not go out as often
- Pain has restricted by social life to home
- I have no social life because of pain

### Section 10: Traveling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

Patient Name: _____ DOB: _____ Today's Date: _____
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**NECK PAIN DISABILITY INDEX QUESTIONNAIRE**

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<b>SECTION 1 - Pain Intensity</b>  A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.	<b>SECTION 6 - Concentration</b>  A I can concentrate fully when I want to with no difficulty. B I can concentrate fully when I want to with slight difficulty. C I have a fair degree of difficulty in concentrating when I want to. D I have a lot of difficulty in concentrating when I want to. E I have a great deal of difficulty in concentrating when I want to. F I cannot concentrate at all.
<b>SECTION 2 - Personal Care (Washing, Dressing, etc.)</b>  A I can look after myself normally without causing extra pain. B I can look after myself normally, but it causes extra pain. C It is painful to look after myself and I am slow and careful. D I need some help, but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, I wash with difficulty and stay in bed.	<b>SECTION 7 - Work</b>  A I can do as much work as I want to. B I can only do my usual work, but no more. C I can do most of my usual work, but no more. D I cannot do my usual work. E I can hardly do any work at all. F I cannot do any work at all.
<b>SECTION 3 - Lifting</b>  A I can lift heavy weights without extra pain. B I can lift heavy weights, but it gives extra pain. C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can lift very light weights. F I cannot lift or carry anything at all.	<b>SECTION 8 - Driving</b>  A I can drive my car without any neck pain. B I can drive my car as long as I want with slight pain in my neck. C I can drive my car as long as I want with moderate pain in my neck. D I cannot drive my car as long as I want because of moderate pain in my neck. E I can hardly drive at all because of severe pain in my neck. F I cannot drive my car at all.
<b>SECTION 4 - Reading</b>  A I can read as much as I want to with no pain in my neck. B I can read as much as I want to with slight pain in my neck. C I can read as much as I want to with moderate pain in my neck. D I cannot read as much as I want because of moderate pain in my neck. E I cannot read as much as I want because of severe pain in my neck. F I cannot read at all.	<b>SECTION 9 - Sleeping</b>  A I have no trouble sleeping. B My sleep is slightly disturbed (less than 1 hour sleepless). C My sleep is mildly disturbed (1-2 hours sleepless). D My sleep is moderately disturbed (2-3 hours sleepless). E My sleep is greatly disturbed (3-5 hours sleepless). F My sleep is completely disturbed (5-7 hours)
<b>SECTION 5 - Headaches</b>  A I have no headaches at all. B I have slight headaches which come infrequently. C I have moderate headaches which come infrequently. D I have moderate headaches which come frequently. E I have severe headaches which come frequently. F I have headaches almost all the time.	<b>SECTION 10 - Recreation</b>  A I am able to engage in all of my recreational activities with no neck pain at all. B I am able to engage in all of my recreational activities with some pain in my neck. C I am able to engage in most, but not all of my recreational activities because of pain in my neck. D I am able to engage in a few of my recreational activities because of pain in my neck. E I can hardly do any recreational activities because of pain in my neck. F I cannot do any recreational activities at all.

**COMMENTS:** \_\_\_\_\_

**SCORE:** \_\_\_\_\_

**Dallas Pain Questionnaire**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Please read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0-100 in each section.

**Section I: Pain and Intensity**

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

None                      Some                      All the time  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section II: Personal Care**

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

None (no pain)      Some                      I can't get out of bed  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section III: Lifting**

How much limitation do you notice in lifting?

None                      Some                      I can't lift anything  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section IV: Walking**

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

The same      Almost the same      Very little      I can't walk  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section V: Sitting**

Back pain limits my sitting in a chair to:

None                      Some                      I can't sit at all  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section VI: Standing:**

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

None (same as before)      Some                      I can't stand  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section VII: Sleeping**

How much does pain interfere with your sleeping?

None (same as before)      Some                      I can't sleep at all  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section VIII: Social Life**

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

None                      Some                      No activities  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section IX: Traveling**

How much does pain interfere with traveling in a car?

None                      Some                      I can't travel  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section X: Vocational**

How much does pain interfere with your job?

None                      Some                      I can't work  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XI: Anxiety/Mood**

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

Total (no change)      Some                      None  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XII: Emotional Control**

How much control do you feel you have over your emotions?

Total (no change)      Some                      None  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XIII: Depression**

How depressed have you been since the onset of pain?

Not Depressed                      Overwhelmed by  
Significantly                      Depression  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XIV: Interpersonal Relationships**

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

Not Changed                      Drastically Changed  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XV: Social Support**

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

None Needed                      All the time  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%

**Section XVI: Punishing Response**

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

None                      Some                      All the time  
0% ( \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ ) 100%