Eric W. Hooley, M.D.
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Patient Name:________________________________ Age:_______ Date:_______________

Please complete all questions. All responses will remain confidential.

1. What is the main reason for your visit?

☐ Back pain ☐ Leg pain ☐ Other:____

2. How long have you had this pain?

☐ _______ days ☐ _______ month(s) ☐ _______ year(s)

3. Please mark where your pain is on the diagram below:

Front

Right Left

Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	OOO	XXX	///
AAA	OOO	XXX	///
AAA	OOO	XXX	///

Pins And Needles

≡ ≡ ≡

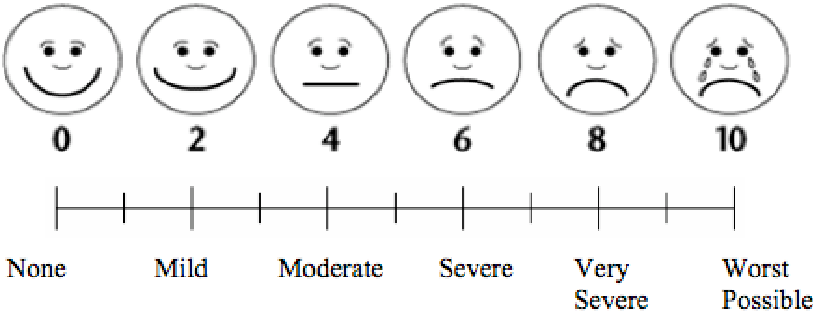
Back

Left Right

Please indicate the percent of pain that you feel in your back and legs:

Back Pain		%
Leg Pain		%
Total	100	%

4. Please place an X on the hash mark that most accurately describes your pain now:



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5. How did the pain begin? ☐ *Unknown* ☐ *Auto accident* ☐ *On the job injury*

☐ ____

____

6. What makes the pain worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Nothing ☐ ________________

7. What makes the pain better?

☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Nothing ☐ ________________

8. Where do you feel weakness?

☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg ☐ No weakness

9. Where has there been a recent CHANGE?

☐ Walking ability ☐ Balance ☐ Writing ability ☐ Ability to button shirt/pants

☐ Controlling urine or stool ☐ No changes

10. How far can you walk?

☐ < 100 yards ☐ 100 - 500 yards ☐ 500 - 1000 yards ☐ > 1000 yards

11. What treatments have you tried for this problem? (Check all that apply)

☐ Nothing ☐ Acupuncture ☐ Chiropractic Care ☐ Rest

☐ Formal Physical Therapy - How many sessions:______________________________

☐ Medications: ☐ Tylenol ☐ Anti-inflammatories (Aleve, Motrin, Advil, etc.)

☐ Muscle relaxants ☐ Pain medications:______________________________

____

☐ Transforaminal epidural steroid injection ☐ Epidural steroid injection ☐ Facet joint injection

12. Please list all Care Givers that have treated you for this condition:

☐ ____

13. Which of the following are involved with your current pain/injury: (Check all that apply)

☐ Workers compensation ☐ Personal lawsuit ☐ Disability claim ☐ Social security claim

14. How were you referred to our practice?

☐ Doctor:________________________ ☐ Emergency Department

☐ Other:____

15. *Is there anything else that you think we should know about?*______________________________

____

____

____

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Past Medical History

☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ Diabetes
☐ Congestive heart failure ☐ Emphysema/COPD ☐ Asthma ☐ Blood clot/DVT/PE
☐ Fibromyalgia ☐ Migraine headaches ☐ Gout ☐ Kidney disease
☐ Bleeding disorder ☐ Low/high thyroid ☐ GERD/ulcers ☐ Liver disease
☐ Osteoporosis ☐ Stroke ☐ Hepatitis ☐ None
☐ Cancer(type:____)
☐ Other:____

____

Past Surgical History

Surgical Procedure	Date	Complication

Medications

Medication	Dose	Frequency
Example: Motrin	600 mg	Three times a day

Allergies ☐ No known drug allergies ☐ ____

Social History Occupation:____

Are you currently working? ☐ Yes ☐ No If yes, how many hours per week?___________
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have any children? ☐ Yes ☐ No If yes, how many?_____________________
Do you live alone? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?____________
Do you chew tobacco? ☐ Yes ☐ No
Any illicit drugs? ☐ Yes ☐ No
Do you drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ Rarely ☐ Never

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Family History

Do you have a family history of:

Diabetes?	☐ Yes	☐ No	DVT or PE (pulmonary embolus)?	☐ Yes	☐ No
Heart disease?	☐ Yes	☐ No	Malignant hyperthermia?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No	Mental health disorders?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No	What type of cancer?________________________________		

Review of Systems

Do you have any current (within the last few weeks) problems with:

Constitutional symptoms

Good general health	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Unexplained weight change	☐ Yes	☐ No

Eyes

Wear glasses or contacts	☐ Yes	☐ No
Change in vision	☐ Yes	☐ No

Ears, nose, mouth, throat

Change in hearing ability	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No

Cardiovascular

Chest pains	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Swelling of feet or ankles	☐ Yes	☐ No
Sudden heartbeat changes	☐ Yes	☐ No

Respiratory

Shortness of breath	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Asthma or wheezing	☐ Yes	☐ No

Gastrointestinal

Nausea or vomiting	☐ Yes	☐ No
Change in bowel movements	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Urinary incontinence	☐ Yes	☐ No

Females only:

Painful periods	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No

Date of last menstrual period ____________

Musculoskeletal

Joint pain	☐ Yes	☐ No
Joint stiffness or swelling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Difficulty walking	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Muscle pain or cramps	☐ Yes	☐ No

Integumentary

Rash or itching	☐ Yes	☐ No
Change in skin, hair or nails	☐ Yes	☐ No

Females only:

Breast pain or lumps	☐ Yes	☐ No

Neurological

Frequent headaches	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Head injury	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Sleep problems	☐ Yes	☐ No

Endocrine

Heat or cold intolerance	☐ Yes	☐ No
Change in hat or glove size	☐ Yes	☐ No
Excessive thirst or urination	☐ Yes	☐ No

Hematologic/lymphatic

Easily bruise or bleed	☐ Yes	☐ No
Slow to heal after cuts	☐ Yes	☐ No
Swollen glands	☐ Yes	☐ No

Allergic/immunologic

Hay fever	☐ Yes	☐ No
Recurrent infections	☐ Yes	☐ No

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Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ 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, wash with difficulty and stay in bed.

SECTION 3 - LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on the table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift light weights at the most.

SECTION 4 - WALKING
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can only walk while using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - SITTING
- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ 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 pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 - SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal, but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 9 - 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.

SECTION 10 - CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

I attest that the above answers are true and have been completed to the best of my knowledge.

Patient Signature:____ **Date/Time:**_____________________

I have reviewed the history and review of systems.

Physician Signature:_____________________________________ Date/Time:_____________________

Min disability 0-18%, Mod 20-38%, Severe 40-58%, Crippling 60-78%, Exaggerated 80-100%   ODI Score:___________