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Spine Care

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

**I. GENERAL INFORMATION:**

Name \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
Dominant Hand: \_\_\_\_\_ Left \_\_\_\_\_ Right Height \_\_\_\_\_ Weight \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  Widowed  
Referred By: \_\_\_\_\_

**RACE/ETHNIC GROUP (please circle):**

African American Caucasian Hispanic Asian American Indian Other \_\_\_\_\_

**WORKING STATUS:**

Presently Employed: Y / N  
 Full-Time  Part-Time  Light Duty  Disabled  Housewife  Retired  
Occupation \_\_\_\_\_

**II. REVIEW OF SYSTEMS**

Have you ever had back surgery?  Yes  No  
When was your last physical examination? \_\_\_\_\_  More than 5 yrs ago  
Do you have any **DRUG ALLERGIES**?  Yes  No  
If YES, please list: \_\_\_\_\_

Have you ever had any of the following conditions? (Circle all that apply)

- |                                      |                                   |
|--------------------------------------|-----------------------------------|
| Previous Blood Transfusions          | Cancer                            |
| Headaches not relieved by medication | Heart Disease                     |
| Colitis                              | HIV                               |
| Migraine Headaches                   | High Blood Pressure               |
| Episodes of Frequent Urination       | Stroke                            |
| Difficult or Painful Urination       | Blood Clots in the Legs           |
| Hepatitis                            | Psoriasis                         |
| Difficulty Breathing                 | Excessive Fatigue                 |
| Diabetes                             | Stomach Ulcers                    |
| Asthma                               | Frequent Episodes of Constipation |
| Seizures                             | Depression                        |
- Previous surgeries (please list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have not had any of the above conditions \_\_\_\_\_ (Initial Here).**

**III. PAST, SOCIAL & FAMILY HISTORY**

Do you SMOKE?  Yes  No #packs per day \_\_\_\_\_ # years smoking \_\_\_\_\_  
(Cigarettes, Cigars, Pipe, Chew Tobacco)  
Do you drink ALCOHOL?  Yes  No #drinks per day \_\_\_\_\_ #per week \_\_\_\_\_ #years drinking \_\_\_\_\_

**Do you have a FAMILY HISTORY of any of the following (please mark):**

	Mother / Father	Grandmother / Grandfather
Cancer	_____/_____	_____/_____
Diabetes	_____/_____	_____/_____
Heart disease	_____/_____	_____/_____
Rheumatoid Arthritis	_____/_____	_____/_____
Arthritis	_____/_____	_____/_____
Stroke	_____/_____	_____/_____

**IV. PRIOR EVALUATION**

PLEASE LIST THE NAME OF ANY PHYSICIAN/FACILITY YOU HAVE BEEN TO FOR YOUR CURRENT PROBLEM:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Have you had any of the following prior treatments for the *CURRENT* problem?**

- Physical Therapy       Massage Therapy       Medication       Chiropractic Treatments  
 Acupuncture       Epidural Injection (s)       Steroid Injection (s)

*Please list any prior BACK OR NECK surgeries you have had:*

<u>SPINE SURGERY</u>	<u>PROCEDURE</u>	<u>LEVELS</u>	<u>DATE</u>
List levels and dates	Lumbar Disc Surgery	_____	_____
	Lumbar Fusion	_____	_____
	Cervical Fusion	_____	_____
	Other: _____	_____	_____

**Please list any medication that you are currently taking**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**V. CHIEF COMPLAINT**

Please give a detailed description of how the pain began: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

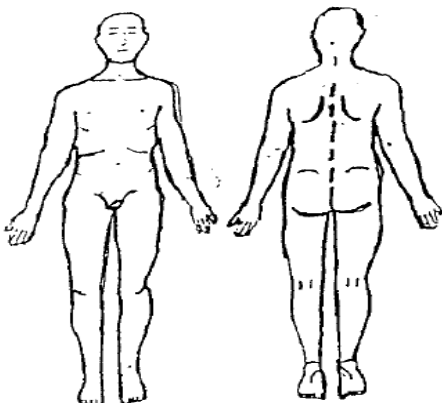
Is there anything that you do that makes you feel better? *(Please describe)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please place an X on the areas below where you have pain**



Visual Analog Pain Scale: Check the level of **NECK** pain today.  
 (0 = none      10 = unbearable)  
 0  1  2  3  4  5  6  7  8  9  10

Visual Analog Pain Scale: Check the level of **BACK** pain today.  
 (0 = none      10 = unbearable)  
 0  1  2  3  4  5  6  7  8  9  10

Visual Analog Pain Scale: Check the level of **ARM** pain today.  
 (0 = none      10 = unbearable)  
 0  1  2  3  4  5  6  7  8  9  10

I have reviewed the current symptomatology, review of symptoms and past medical, family and social history.

Visual Analog Pain Scale: Check the level of **LEG** pain today.  
 (0 = none      10 = unbearable)  
 0  1  2  3  4  5  6  7  8  9  10

# SF-36® Health Survey

1. In general, would you say your health is:

Excellent      Very good      Good      Fair      Poor

2. *Compared to one year ago*, how would you rate your health in general *now*?

Much better      Somewhat better now      About the same      Somewhat worse      Much worse now

3. The following questions are about activities you might do during a typical day. Does your health *now* limit you in these activities? If so, how much?

a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports

b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

c. Lifting or carrying groceries

d. Climbing **several** flights of stairs

e. Climbing **one** flight of stairs

f. Bending, kneeling, or stooping

g. Walking **more than a mile**

h. Walking **several blocks**

i. Walking **one block**

j. Bathing or dressing yourself

Yes, limited a lot      Yes, limited a little      No, not limited at all

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities	1	2	3
b. Moderate activities	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *as a result of your physical health*?

a. Cut down on the **amount of time** you spent on work or other activities

b. **Accomplished less** than you would like

c. Were limited in the **kind** of work or other activities

d. Had **difficulty** performing the work or other activities (for example, it took extra effort)

Yes      No

	Yes	No
a. Cut down on the amount of time	1	2
b. Accomplished less	1	2
c. Were limited in the kind	1	2
d. Had difficulty	1	2

5. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

a. Cut down on the **amount of time** you spent on work or other activities

b. **Accomplished less** than you would like

c. Didn't do work or other activities as **carefully** as usual

Yes      No

	Yes	No
a. Cut down on the amount of time	1	2
b. Accomplished less	1	2
c. Didn't do work or other activities as carefully	1	2

6. During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

**Not at all                      Slightly                      Moderately                      Quite a bit                      Extremely**

7. How much *bodily* pain have you had during the *past 4 weeks*?

**None                      Very mild                      Mild                      Moderate                      Severe                      Very severe**

8. During the *past 4 weeks*, how much did pain interfere with your normal work (including both work outside the home and housework)?

**Not at all                      A little bit                      Moderately                      Quite a bit                      Extremely**

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

	<b>All of the time</b>	<b>Most of the time</b>	<b>A Good Bit of</b>	<b>Some of the time</b>	<b>A little of the time</b>	<b>None of the time</b>
Did you feel full of pep?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Have you been a very nervous person?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Have you felt so down in the dumps that nothing could cheer you up?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Have you felt calm and peaceful?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Did you have a lot of energy?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Have you felt downhearted and blue?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Did you feel worn out?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Have you been a happy person?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
Did you feel tired?	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>

10. During the *past 4 weeks*, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

**All of the time                      Most of the time                      Some of the time                      A little of the time                      None of the time**

11. How TRUE or FALSE is *each* of the following statements for you?

	<b>Definitely true</b>	<b>Mostly true</b>	<b>Don't know</b>	<b>Mostly false</b>	<b>Definitely false</b>
I seem to get sick a little easier than other people	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
I am as healthy as anybody I know	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
I expect my health to get worse	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
My health is excellent	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

## Oswestry Low Back Questionnaire

### **Pain Intensity**

- 0 I can tolerate the pain I have without having to use pain medication.
- 1 The pain is bad, but I can manage without pain medication.
- 2 Pain medication provides me with complete relief from pain.
- 3 Pain medication provides me with moderate relief from pain.
- 4 Pain medication provides me with little relief from pain.
- 5 Pain medication has no effect on my pain.

### **Personal Care (e.g., Washing, Dressing)**

- 0 I can take care of myself normally without causing increased pain.
- 1 I can take care of myself normally, but it increases my pain.
- 2 It is painful to take care of myself, and I am slow and careful.
- 3 I need help, but I am able to manage most of my personal care.
- 4 I need help every day in most aspects of my care.
- 5 I do not get dressed, I wash with difficulty, and I stay in bed.

### **Lifting**

- 0 I can lift heavy weights without increased pain.
- 1 I can lift heavy weights, but it causes increased pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift only very light weights.
- 5 I cannot lift or carry anything at all.

### **Walking**

- 0 Pain does not prevent me from walking any distance.
- 1 Pain prevents me from walking more than 1 mile.
- 2 Pain prevents me from walking more than 1/2 mile.
- 3 Pain prevents me from walking more than 1/4 mile.
- 4 I can walk only with crutches or a cane.
- 5 I am in bed most of the time and have to crawl to the toilet.

### **Sitting**

- 0 I can sit in any chair as long as I like.
- 1 I can only sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting for more than 1 hour.
- 3 Pain prevents me from sitting for more than 1/2 hour.
- 4 Pain prevents me from sitting for more than 10 minutes.
- 5 Pain prevents me from sitting at all.

### **Standing**

- 0 I can stand as long as I want without increased pain.
- 1 I can stand as long as I want, but it increases my pain.
- 2 Pain prevents me from standing for more than 1 hour.
- 3 Pain prevents me from standing for more than 1/2 hour.
- 4 Pain prevents me from standing for more than 10 minutes.
- 5 Pain prevents me from standing at all.

### **Sleeping**

- 0 Pain does not prevent me from sleeping well.
- 1 I can sleep well only by using pain medication.
- 2 Even when I take medication, I sleep less than 6 hours.
- 3 Even when I take medication, I sleep less than 4 hours.
- 4 Even when I take medication, I sleep less than 2 hours.
- 5 Pain prevents me from sleeping at all.

### **Social Life**

- 0 My social life is normal and does not increase my pain.
- 1 My social life is normal, but it increases my level of pain.
- 2 Pain prevents me from participating in more Energetic activities (e.g., sports, dancing).
- 3 Pain prevents me from going out very often.
- 4 Pain has restricted my social life to my home.
- 5 I have hardly any social life because of my pain.

### **Traveling**

- 0 I can travel anywhere without increased pain.
- 1 I can travel anywhere, but it increases my pain.
- 2 My pain restricts my travel over 2 hours.
- 3 My pain restricts my travel over 1 hour.
- 4 My pain restricts my travel to short necessary Journeys under 1/2 hour.
- 5 My pain prevents all travel except for visits to the physician / therapist or hospital.

### **Employment / Homemaking**

- 0 My normal homemaking / job activities do not cause pain.
- 1 My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- 2 I can perform most of my homemaking / job duties, but Pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- 3 Pain prevents me from doing anything but light duties.
- 4 Pain prevents me from doing even light duties.
- 5 Pain prevents me from performing any job or home chores.