Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Complete New Patient Paperwork Online! Visit epic.mycenturahealth.org to complete your Health History Questionnaire and update your information.

PATIENT INFORMATION

Name: _____ SSN: _____
Last First MI

Sex: ☐ M ☐ F DOB: _____ Preferred Name: _____

Address: _____
City State Zip

Mailing address: ☐ Check if same as above

_____
Address

_____
City State Zip

Home Phone: _____ Cell: _____

Email:

Marital Status(Circle): Divorced Legally Separated Married Significant Other Single Widowed Declined

Would you prefer to speak to your healthcare provider through a translator? Yes No

Preferred Language: English Other (please specify): _____ Written Language: _____

Religion: _____ or circle to Decline Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ____ Yes ____ No ____ Declined

Race circle: American Indian or Alaska Native Native Hawaiian or other Pacific Islander White
Black or African American Asian Declined

Employer: _____ Employer Phone: _____ Occupation: _____

Status: __ Part-time ___ Full-time ___ Self-Employed ___Retired ___Active Military ____ Disabled ___Unemployed

PHARMACY	Address/Cross Streets	Phone Number	Preferred
Local: _____	_____	_____	
Alternative: _____	_____	_____	Mail
Order: _____	_____	_____	

CARE TEAM

Primary Care Provider. _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

Specialist Name: Specialty: _____ Phone Number: _____

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

EMERGENCY CONTACT

Name: LAST_____ FIRST _____ Relation to patient: _____
Address: _____
Phone: _____

Name: LAST_____ FIRST _____ Relation to patient: _____
Address: _____
Phone: _____

PARTY RESPONSIBLE FOR PAYMENT Check if same as patient _____
Name: LAST_____ FIRST _____ Relation to patient: _____
Address: _____
Phone: _____
SSN:_____ Relation to patient: _____
Employer: _____

Advance Directives:
Do you have a Living Will / DNR? _____ Yes _____ No
Do you have a Durable Power of Attorney? __ Yes __No
If yes:_____
Please Print Name Phone Number Would you like information regarding Advance Directive? ___Yes __No

---

Chief Complaint (Reason for Visit):

_____

ALLERGIES: ____ No Known Drug Allergies
Medication: _____Reaction: _____
Medication: _____Reaction: _____
Medication: _____Reaction:_____
Other (latex, adhesive, food, environment): Other (latex, adhesive, food, environment):
_____

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

MEDICATIONS: ___ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

PATIENT INFORMATION:

Name: LAST _____ FIRST _____ DOB: _____

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes ☐ No	Hepatitis - Type: _____	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Angina (Heart pain)	☐ Yes ☐ No	Hyperlipidemia (High cholesterol)	☐ Yes ☐ No
Arrhythmia/Palpitations	☐ Yes ☐ No	Hypertension (High blood pressure)	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Long-Term Steroid Use	☐ Yes ☐ No
Bleeding disorder/tendency	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	MI (Heart attack) - Date: _____	☐ Yes ☐ No
Bone Loss - DEXA: _____ Date	☐ Yes ☐ No	Motor Vehicle Accident	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Oxygen Use	☐ Yes ☐ No
Chronic Fatigue	☐ Yes ☐ No	Peripheral Artery Disease	☐ Yes ☐ No
Chronic Kidney Disease	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Chronic Pain	☐ Yes ☐ No	Restless Leg Syndrome	☐ Yes ☐ No
Connective Tissue Disorder	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
COPD/Emphysema	☐ Yes ☐ No	Sciatica	☐ Yes ☐ No
CVA/Stroke	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Diabetes - Type:	☐ Yes ☐ No	Seasonal Allergies: _____	☐ Yes ☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Disabilities: _____	☐ Yes ☐ No	Sinusitis, recurrent	☐ Yes ☐ No
Diverticulitis	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Ear Infection, recurrent	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Environmental/Food Allergies: _____	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	UTI (Bladder infections)	☐ Yes ☐ No
Genetic/Congenital Condition: _____	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No
GERD (Heartburn)	☐ Yes ☐ No	Other Conditions: _____	
GI Bleeding	☐ Yes ☐ No	_____	
Glaucoma	☐ Yes ☐ No	_____	
Gunshot Wound	☐ Yes ☐ No	Date of last dental exam: _____	
Head Injury/Concussion	☐ Yes ☐ No	Date of last eye exam: _____	
Hearing Deficit	☐ Yes ☐ No	**Date of last colonoscopy:** _____	
Heart Disease	☐ Yes ☐ No	Doctor: _____	
Heart Failure	☐ Yes ☐ No	History of colon polyps	☐ Yes ☐ No

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Name: LAST _____ FIRST _____ DOB: _____

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ___ Yes ____ No

Additional Personal Medical History

_____

_____

_____

FEMALE PATIENTS ONLY

C) Abnormal Pap smear

C] Other GYN history (indicate below)

Age of first menstrual period: _____

Date of last menstrual period: _____

Age of menopause: _____

Form Of contraception (if any): _____

Last mammogram: _____

Last Pap smear: _____

Currently pregnant? D Yes C] No

Currently breastfeeding? C] Yes C] No

Planning pregnancy? Yes No

Number of Pregnancies: _____

Number of Deliveries: _____

Number of Elective abortions: _____

Number of Miscarriages: _____

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

SOCIAL HISTORY

Tobacco: __None Quit Date: _____

__ Pipe/Cigar ___ Cigarettes Packs/Day: _____ Number of years smoked: _____

__ Smokeless tobacco ____ Electronic or E-Cigarette Secondhand smoke exposure: _____

Alcohol Use: ___ None ___ Daily ____Occasional _____ Trying to cut down ____ In recovery

Amount per week: _____

Drug Use: ☐ None ☐ Past Use ☐ Current

How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?

☐ None ☐ One or more ☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club

Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

Sexual Activity: ☐ Not active ☐ Active Number of lifetime sexual partners: _____ ☐ Men ☐ Women ☐ Both

Do you have a caregiver? Yes ☐ No

Name: _____ Relationship:_____

Diet: ☐ Well Balanced ☐ Diabetic ☐ Vegetarian ☐ Fast food/Fats/Carbs ☐ Vitamins/Herbs ☐ Weight Loss Products:

_____

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Stretch/Balance

☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Parents ☐ Assisted Living:_____

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Technical/ Trade

Occupation:_____

Leisure activities: _____

_____

Religion:_____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home

Abuse:

I feel safe at home: ☐ Yes ☐ No

Is there anyone you are afraid of? ☐ Yes ☐ No

Do you have a history of abuse? ☐ Yes ☐ No

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Travel:

In the last 30 days, have you traveled to any foreign countries? ☐ Yes ☐ No List: _____

IMMUNIZATIONS

Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis: DATE: _____ Influenza: DATE: _____ Shingles: DATE: _____
Meningitis: DATE: _____ Hepatitis A: DATE: _____ Hepatitis B: DATE: _____
HPV: DATE: _____ Pneumococcal 13 or 23: DATE: _____ / DATE: _____
OTHER: _____ DATE: _____

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

_____

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Name: LAST: _____FIRST: _____ DOB: _____

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes below, it known.

Relationship	Name	Status	No Known Problems	Alcohol abuse	Asthma	Blood clots	Breast cancer	Colon cancer	Prostate cancer	Other cancer(s)	Dementia	Diabetes	Heart disease	High blood pressure	High cholesterol	Kidney disease	Liver disease	Lung disease	Mental illness	Ovarian Cancer	Stroke	Thyroid condition(s)	Other:_____	Other:_____	Other:_____
Mother		☐ Alive ☐ Deceased																							
Father		☐ Alive ☐ Deceased																							
Sister		☐ Alive ☐ Deceased																							
Brother		☐ Alive ☐ Deceased																							
Son		☐ Alive ☐ Deceased																							
Daughter		☐ Alive ☐ Deceased																							
Maternal Grandmother		☐ Alive ☐ Deceased																							
Maternal Grandfather		☐ Alive ☐ Deceased																							
Paternal Grandmother		☐ Alive ☐ Deceased																							
Paternal Grandfather		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							
Other:_____		☐ Alive ☐ Deceased																							

Are you adopted?: ☐ Yes ☐ No

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS:**

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts

Any other symptoms: _____

_____

_____ Patient or Guardian Name (please print)

_____ Patient or Guardian Signature

_____ Date

Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

SPINE QUESTIONNAIRE
Colorado Comprehensive Spine Institute

Date: _____ ☐ Male ☐ Female

Patient Name: _____ Date of Birth: _____
Referring Physician: _____ Phone: _____
Primary Care: _____

Physician:_____

Phone: If not referred by a doctor, how did you hear about us?

HISTORY OF PRESENT COMPLAINT

Where is your problem located? ☐ Neck ☐ Upper Back ☐Arm ☐ Lower Back ☐ Hip ☐ Leg

How long have you had this problem? _____ Since _____/_____/_____

Briefly, please describe the onset of your current back/neck pain and the events preceding your pain:

_____
_____
_____
_____
_____

Was this from a work-related injury? ☐ No ☐ Yes
Is it under Workers Compensation? ☐ No ☐ Yes

Have you missed any work because of this problem? ☐ No ☐ Yes

How Much? _____

Was this from an auto injury? ☐ No ☐ Yes

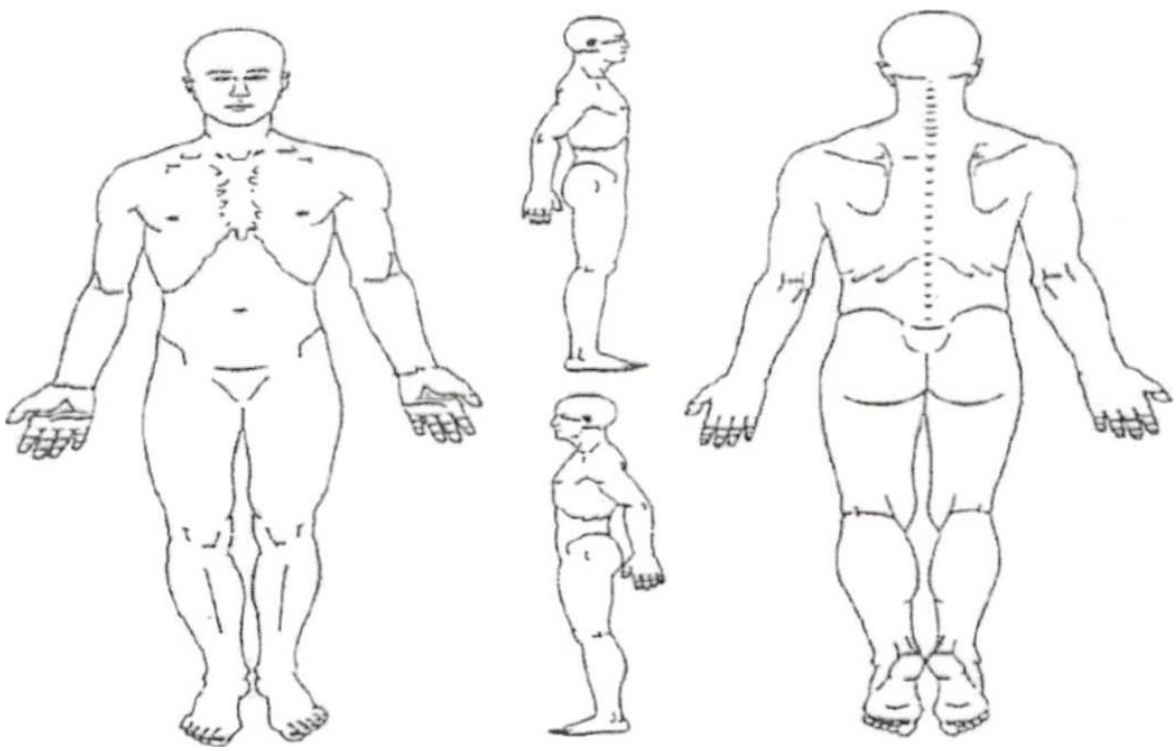
Colorado Comprehensive SPINE INSTITUTE

Centura Health Physician Group

Centura Health. Patient Information PG-2000 rev. 03/17

Please indicate where you have pain by marking the areas on your body where you have the described sensations. Use the appropriate symbol:

ACHE >>>> NUMBNESS ------- PINS & NEEDLES 0000 BURNING XXXX STABBING ////



PAIN SCALE
Colorado Comprehensive Spine Institute

Circle a number to indicate the level of your pain for the current injury in the situations listed below:

PAIN TODAY	0	1	2	3	4	5	6	7	8	9	10
GREATEST PAIN	0	1	2	3	4	5	6	7	8	9	10
PAIN AT REST	0	1	2	3	4	5	6	7	8	9	10

Which of the following activities change the nature of your pain?

_____

_____

Oswestry Disability Index

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, etc.)

- ❑ I can look after myself normally but it is very painful.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects 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 gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or 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.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for 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 more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ 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 sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours 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 cause 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 limitingmy more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my 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 extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Neck Disability Index

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

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain. (0)
- ❑ I can look after myself normally but it causes extra pain. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of self care. (4)
- ❑ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

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

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty. (0)
- ❑ I can concentrate fully when I want to with slight difficulty. (1)
- ❑ I have a fair degree of difficulty in concentrating when I want to. (2)
- ❑ I have a lot of difficulty in concentrating when I want to. (3)
- ❑ I have a great deal of difficulty in concentrating when I want to. (4)
- ❑ I cannot concentrate at all. (5)

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ❑ I have no trouble sleeping. (0)
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ❑ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

0-4	**No disability**
5-14	**Mild disability**
15-24	**Moderate disability**
25-34	**Severe disability**
> 35	**Complete disability**

Functional Strength of the Cervical Spine

Starting Position	Action	Functional Test
Supine lying	Lift head keeping chin tucked in (neck flexion)	6 to 8 repetitions: functional 3 to 5 repetitions: functionally fair 1 to 2 repetitions: functionally poor 0 repetitions: nonfunctional
Prone lying	Lift head backward (neck extensions)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional
Side lying (pillows under head so head is not side flexed)	Life head sideways away from pillow (neck side flexion) (must be repeated or other side)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional
Supine lying	Lift head off bed and rotate to one side keeping head off bed or pillow (neck rotation) (must be repeated both ways)	Hold 20 to 25 seconds: functional Hold 10 to 19 seconds: functionally fair Hold 1 to 9 seconds: functionally poor Hold 0 seconds: nonfunctional

SCORING TECHNIQUE FOR THE OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE AND NECK DISABILITY INDEX

1. Each of the 10 sections is scored separately (0 to 5 points each) and then added up (max. total = 50).

Example:

Section 1. Pain Intensity	Point Value
A. ___ I have no pain at the moment	0
B. ___ The pain is very mild at the moment	1
C. ___ The pain is moderate at the moment	2
D. ___ The pain is fairly severe at the moment	3
E. ___ The pain is very severe at the moment	4
F. ___ The pain is the worst imaginable	5

2. If all 10 sections are completed, simply double the patient's score.
3. If a section is omitted, divide the patient's total score by the number of sections completed times 5.

Formula:

$$\frac{\text{Patient's Score}}{\text{No. of sections completed} \times 5} \times 100 = \_\_\_\_\_ \%\ \text{DISABILITY}$$

Example:

If 9 of 10 sections are completed, divide the patient's score by 9 x 5 = 45.

Patient's Score 22
Number of sections completed: 9 (9 x 5 = 45)
22/45 x 100 = 48% disability

4. Interpretation of disability scores (from original article):

SCORE INTERPRETATION OF THE OSWESTRY LBP DISABILITY QUESTIONNAIRE	
0-20% Minimal disability	Can cope with most ADLs. Usually no treatment is needed, apart from advice on lifting, sitting, posture, physical fitness, and diet. In this group, some patients have particular difficulty with sitting and this may be important if their occupation is sedentary (typist, driver, etc.)
20-40% Moderate disability	This group experiences more pain and problems with sitting, lifting, and standing. Travel and social life are more difficult and they may well be off work. Personal care, sexual activity, and sleeping are not grossly affected, and the back condition can usually be managed by conservative means.
40-60% Severe disability	Pain remains the main problem in this group of patients, but travel, personal care, social life, sexual activity, and sleep are also affected. These patients require detailed investigation.
60-80% Crippled	Back pain impinges on all aspects of these patients' lives both at home and at work. Positive intervention is required.
80-100%	These patients are either bed-bound or exaggerating their symptoms. This can be evaluated by careful observation of the patient during the medical examination.
Data compiled from Fairbanks et al, 1980.	