

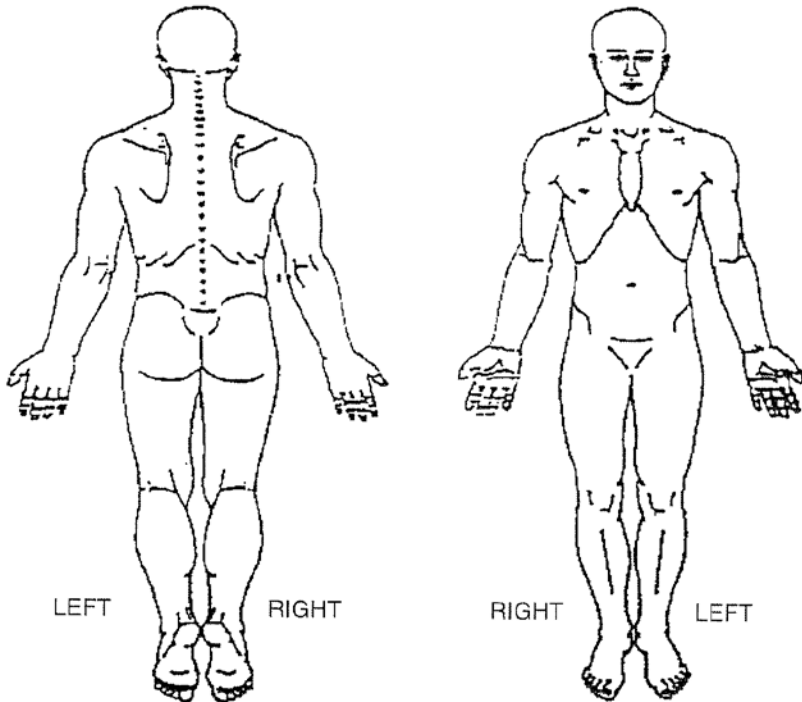
# Fort Worth Orthopedics

Dr. Mark Wylie • Dr. William Mitchell • Dr. Carson Fairbanks

PATIENT NAME:	AGE:	DOB:
DATE OF VISIT:		

Mark these drawings according to where you hurt. If the back of your neck hurts, mark the drawing on the back of the neck, etc. If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

<u>Numbness</u> =====	<u>Burning</u> XXXXXXXXXX	<u>Ache</u> AAAAAAAAAA	<u>Pins &amp; Needles</u> 000000000	<u>Stabbing</u> //////////
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How would you describe your current pain ratio? (Please check one box)

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
✓	% Back Pain	% Leg Pain	✓	% Neck Pain	% Arm Pain
<input type="checkbox"/>	100 %	0%	<input type="checkbox"/>	100%	0%
<input type="checkbox"/>	75%	25%	<input type="checkbox"/>	75%	25%
<input type="checkbox"/>	50%	50%	<input type="checkbox"/>	50%	50%
<input type="checkbox"/>	25%	75%	<input type="checkbox"/>	25%	75%
<input type="checkbox"/>	0%	100%	<input type="checkbox"/>	0%	100%

HEIGHT:
WEIGHT:
RADIAL PULSE:

**Current Pain Intensity**

**Please circle the number which best describes your current pain level**  
(0 represents "no pain")

<b>Today</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Best Day</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Worst Day</b>	0	1	2	3	4	5	6	7	8	9	10

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PATIENT NAME:		DOB:	
Sex: M or F	Age:	Dominant Hand	R or L
Date Your Pain Started:			
Name of Physician			
Which physician referred you to Fort Worth Orthopedics?		Office Address	
What is the main reason for your visit?			
What are your present symptoms?			
Describe how the injury occurred?			
Did you sustain any other injuries at the time of this injury? If yes, please describe.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this injury work related?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Is there any upcoming worker's compensation hearing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Do you have a lawyer for your injury?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Did an automobile accident cause your pain?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unsure
Description of the accident			
Were you wearing a seatbelt?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there upcoming litigation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get leg pain as you walk?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How far can you walk? (check one box)		<input type="checkbox"/> Less than 1 block	<input type="checkbox"/> 1 block <input type="checkbox"/> 5-10 blocks <input type="checkbox"/> more than 1 mile
If you sit down after you walk, does your leg pain get better?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long have you had your current pain? (check one box)		<input type="checkbox"/> Unknown <input type="checkbox"/> About 1 Day <input type="checkbox"/> About 3 days <input type="checkbox"/> About 1 week <input type="checkbox"/> About 1 month <input type="checkbox"/> About 3 months	<input type="checkbox"/> About 6 months <input type="checkbox"/> About 6 months to 1 year <input type="checkbox"/> About 1 to 2 years <input type="checkbox"/> About 2 to 3 years <input type="checkbox"/> About 3 to 5 years <input type="checkbox"/> More than 5 years

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PATIENT NAME:	DOB:
Have you recently or are you now experiencing numbness and/or tingling in your leg, foot, arm or hand? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left	
If yes, in which body part?	
Have you recently or are you now experiencing weakness in your arms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left	
In your legs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left	
Have you experienced any of the following changes in urination? <input type="checkbox"/> Increased frequency <input type="checkbox"/> Inability to hold urine <input type="checkbox"/> Dribbling after voiding <input type="checkbox"/> Cannot pass urine	
Have you experienced any of the following changes in your bowels? <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loss of control	
Have you noticed changes in sexual function? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what?	
Do you have headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you recently been depressed because of your pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
Does the pain wake you up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many hours per night do you sleep?	
Is the pain in your back and neck constant or intermittent? <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Is the pain in your leg and arm constant or intermittent? <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Which word in each group best describes your pain? <input type="checkbox"/> Dull <input type="checkbox"/> Superficial <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing <input type="checkbox"/> Sharp <input type="checkbox"/> Deep <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Shooting	
Does the pain keep you from participating in activities you enjoy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your pain severe enough to consider surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please mark the activities that make your <u>pain worse</u></b>	
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Leaning forward <input type="checkbox"/> Walking <input type="checkbox"/> Lying on your side <input type="checkbox"/> Lying on your back <input type="checkbox"/> Lying on your stomach <input type="checkbox"/> Driving <input type="checkbox"/> Coughing/Sneezing <input type="checkbox"/> Lifting <input type="checkbox"/> Getting out of bed	
<b>Please mark the activities that make your <u>pain better</u>:</b>	
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Leaning forward <input type="checkbox"/> Walking <input type="checkbox"/> Lying on your side <input type="checkbox"/> Lying on your back <input type="checkbox"/> Lying on your stomach <input type="checkbox"/> Driving <input type="checkbox"/> Coughing/Sneezing <input type="checkbox"/> Lifting <input type="checkbox"/> Getting out of bed	

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PATIENT NAME:	DOB:
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Please check the boxes next to those treatments you have used for your present condition. Then indicate whether the treatment was helpful or not helpful.

Treatment	Helpful	Not Helpful
<input type="checkbox"/> <b>Physical therapy</b> If so, how many visits?		
<input type="checkbox"/> <b>Hot packs/ice, massage, muscle stimulation, ultrasound, etc.</b>		
<input type="checkbox"/> <b>Exercise for proper posture</b> (stabilization)		
<input type="checkbox"/> <b>Exercise to build strength/endurance</b> (bike, treadmill, etc)		
<input type="checkbox"/> <b>Back School Education</b>		
<input type="checkbox"/> <b>Work hardening/conditioning</b>		
<input type="checkbox"/> <b>Traction</b>		
<input type="checkbox"/> <b>Chiropractic Adjustment</b>		
<input type="checkbox"/> <b>Acupuncture</b>		
<input type="checkbox"/> <b>Epidural Injection</b> If so, how many visits have you had?		
<input type="checkbox"/> <b>TENS Unit</b>		
<input type="checkbox"/> <b>Pain Medicine</b>		
<input type="checkbox"/> <b>Prednisone</b>		
<input type="checkbox"/> <b>Brace</b>		

Please mark the following tests you have undergone for your present condition

Test	Date of Testing	Location of Testing (Hospital etc.)	Place a check for those results you will bring or have sent to THC
<input type="checkbox"/> <b>Regular spine x-ray</b>			
<input type="checkbox"/> <b>CT Scan</b>			
<input type="checkbox"/> <b>MRI</b>			
<input type="checkbox"/> <b>Myelogram</b>			
<input type="checkbox"/> <b>EMG (needle test)</b>			
<input type="checkbox"/> <b>Discogram</b>			
<input type="checkbox"/> <b>Bone Scan</b>			

Have you had back or neck problems before? If yes, describe below.  Yes  No

Description of Injury	Description of Injury	Months off Work

Have you had any previous injuries at work? If yes, describe below.  Yes  No

Description of Injury	Description of Injury	Months off Work

If you had previous episodes, did they cause any of the following?

<input type="checkbox"/> <b>Back or neck pain only</b>			
<input type="checkbox"/> <b>Leg or arm pain only</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>
<input type="checkbox"/> <b>Back pain and leg pain</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>
<input type="checkbox"/> <b>Neck pain and arm pain</b>	<input type="checkbox"/> <b>Right</b>	<input type="checkbox"/> <b>Left</b>	<input type="checkbox"/> <b>Both</b>

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Have you had any previous surgeries on or relating to your **neck or back** ?       Yes       No

Procedure	Date	Surgeon

What were your symptoms before your last surgery?

<input type="checkbox"/> Back pain only <input type="checkbox"/> Back pain and right leg pain <input type="checkbox"/> Back and left leg pain <input type="checkbox"/> Back and pain in both legs	<input type="checkbox"/> Neck pain only <input type="checkbox"/> Neck and right arm pain <input type="checkbox"/> Neck and left arm pain <input type="checkbox"/> Neck and pain in both arms
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Did you improve after your last surgery?

How long were you better after your last surgery?

<input type="checkbox"/> Unknown <input type="checkbox"/> 1 day <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	<input type="checkbox"/> 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 1 year	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> more than 5 years
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What was your work status after your last surgery?

Returned to same job  
 Returned to same job part-time or light duty  
 Retrained and worked at a new job  
 Never returned to work

List below all the physicians, chiropractors and clinics you have consulted for your present condition.

Name	Address	Date of 1 <sup>st</sup> visit	Date Last Visit

How many hours of your usual work day do you spend?

Sitting: \_\_\_\_\_ Standing: \_\_\_\_\_ Walking: \_\_\_\_\_ Driving: \_\_\_\_\_ Lifting: \_\_\_\_\_ How Heavy?

Which type of duty are you currently working:       Light duty       Heavy duty

Do you want a different job?       Yes       No

Do you plan to return to your job?       Yes       No

**Past Medical History** (Please check any of the following problems you have had in the past)

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Attack <input type="checkbox"/> Seizure <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Night Sweats <input type="checkbox"/> Blood Clots	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Hepatitis (Yellow Jaundice) <input type="checkbox"/> Asthma <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Change in Ability to Pass Urine <input type="checkbox"/> Fever	<input type="checkbox"/> Difficulty in Bowel Movements <input type="checkbox"/> Prostatic Problems <input type="checkbox"/> Kidney Infections <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Swelling of Toe or Finger Joints <input type="checkbox"/> Headaches <input type="checkbox"/> Infections <input type="checkbox"/> Depression <input type="checkbox"/> Strokes <input type="checkbox"/> Other
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Please list **ALL PAST HOSPITALIZATIONS** and **ALL PAREVIOUS SURGERY**. If none, circle: **NONE**

Past Illnesses or Surgeries	Date

**Medications**

Do you have any allergies to medications? If yes, which ones?       Yes     No

Which medications are you currently using for your back or neck:

Medication	# per day	Medication	# per day

Which medications did you previously use for your back or neck:

Medication	# per day	Medication	# per day

Which medications are you taking for other problems? List all of your medications

Medication	# per day	Medication	# per day

**Social History**

Are you?     Single     Married     Divorced     Widow/Widower

If married, what is the age, health

And occupation of your spouse?      Age:                      Health:                      Occupation:

How much schooling have you completed?

- Completed less than high school
- Graduated from high school
- Completed 1 to 3 year of college
- Graduated from a 2 year associate degree program or technical school
- Graduated from college (Bachelor’s degree or equivalent)
- Completed post-graduate or professional degree

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PATIENT NAME:	DOB:
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<b>Children</b>	Age: Living at home:	
	Age: Living at home:	
	Age: Living at home:	
<b>Habits</b>		
<b>Drug Use:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Amount/day:
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Amount/day:
Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Packs/day:
Have you ever had problems with alcohol or drug abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Family History**

<b>Father:</b> <input type="checkbox"/> Alive & Well <input type="checkbox"/> Died	Age:	Cause of Death:
<b>Mother:</b> <input type="checkbox"/> Alive & Well <input type="checkbox"/> Died	Age:	Cause of Death:
Did you have a happy childhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a history of difficulty with anesthesia? If yes, please describe _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a history of malignant hyperthermia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a bleeding tendency in your family or yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Occupational History**

Name of Employer:	
Occupation:	How long?
Date Last Worked:	Previous Employment:

Please mark your current symptoms below. If you have none, please circle: **NONE**

<input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Rashes <input type="checkbox"/> Birthmarks <input type="checkbox"/> Open wounds or sores <input type="checkbox"/> Drainage <input type="checkbox"/> Multiple joint pain <input type="checkbox"/> Multiple joint swelling <input type="checkbox"/> Multiple joint stiffness <input type="checkbox"/> Generalized muscle weakness	<input type="checkbox"/> Frequent or unusual headache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Mouth or dental infection <input type="checkbox"/> Loss of vision <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Productive cough <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Blood clots in legs or lungs <input type="checkbox"/> Varicose veins <input type="checkbox"/> Deformity	<input type="checkbox"/> Bleeding problems <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea-chronic <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequency of urine <input type="checkbox"/> Urgency of urine <input type="checkbox"/> Retention of urine <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Depression <input type="checkbox"/> Episodes of mania <input type="checkbox"/> Inability to sleep
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PATIENT SIGNATURE:	DATE:
History Reviewed By	Date:
	Date:
	Date:

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PATIENT NAME:	DOB:
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Please tell us **HOW PAIN HAS AFFECTED YOUR ABILITY TO PERFORM** the following daily activities during the last four weeks.

<p><b>Dressing</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can usually dress myself without pain</li> <li><input type="checkbox"/> I can dress myself without increasing pain</li> <li><input type="checkbox"/> I can dress myself but pain increased</li> <li><input type="checkbox"/> I can dress myself but have significant pain</li> <li><input type="checkbox"/> I can dress myself but with very severe pain</li> <li><input type="checkbox"/> I cannot dress myself</li> </ul>	<p><b>Sleeping</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I sleep well</li> <li><input type="checkbox"/> Pain occasionally interrupts my sleep</li> <li><input type="checkbox"/> Pain interrupts my sleep half of the time</li> <li><input type="checkbox"/> Pain often interrupts my sleep</li> <li><input type="checkbox"/> Pain always interrupts my sleep</li> <li><input type="checkbox"/> I never sleep well</li> </ul>
<p><b>Lifting</b> ( check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy objects without pain</li> <li><input type="checkbox"/> I can lift heavy objects but it is painful</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy objects but I can manage if they are on a table</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy objects but I can manage light to medium objects if they are on a table</li> <li><input type="checkbox"/> I can only lift light objects</li> <li><input type="checkbox"/> I cannot lift anything</li> </ul>	<p><b>Social and Recreational Life</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social and recreational life is unchanged</li> <li><input type="checkbox"/> My social and recreational life is unchanged but it increases pain</li> <li><input type="checkbox"/> My social and recreational life is unchanged but it severely increases pain</li> <li><input type="checkbox"/> Pain has restricted my social and recreational life</li> <li><input type="checkbox"/> Pain has severely restricted my social and recreational life</li> <li><input type="checkbox"/> I have essentially no social and recreational life because of pain</li> </ul>
<p><b>Walking</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from walking</li> <li><input type="checkbox"/> Pain prevents me from walking more than 1 hour</li> <li><input type="checkbox"/> Pain prevents me from walking more than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from walking more than 10 minutes</li> <li><input type="checkbox"/> I can only walk a few steps at a time</li> <li><input type="checkbox"/> I am unable to walk</li> </ul>	<p><b>Traveling</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere</li> <li><input type="checkbox"/> I can travel anywhere but it gives me pain</li> <li><input type="checkbox"/> Pain is bad but I can manage to travel over 2 hours</li> <li><input type="checkbox"/> Pain restricts me to trips of less than 1 hour</li> <li><input type="checkbox"/> Pain restricts me to trips of less than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from traveling</li> </ul>
<p><b>Sitting</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like</li> <li><input type="checkbox"/> I can only sit in a special chair for as long as I like</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1 hour</li> <li><input type="checkbox"/> Pain prevents me from sitting for more than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from sitting more than a few minutes</li> <li><input type="checkbox"/> Pain prevents me from sitting at all</li> </ul>	<p><b>Sex Life</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is unchanged</li> <li><input type="checkbox"/> My sex life is unchanged but causes some extra pain</li> <li><input type="checkbox"/> My sex life is nearly unchanged but is very painful</li> <li><input type="checkbox"/> My sex life is severely restricted by pain</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain</li> <li><input type="checkbox"/> Pain prevents any sex life at all</li> </ul>
<p><b>Standing</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want</li> <li><input type="checkbox"/> I can stand as long as I want but it gives me pain</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes</li> <li><input type="checkbox"/> Pain prevents me from standing at all</li> </ul>	<p><b>Pain Intensity</b> (check one box)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can tolerate the pain I have without having to use pain killers.</li> <li><input type="checkbox"/> The pain is bad but I manage without taking pain killers</li> <li><input type="checkbox"/> Pain killers give complete relief from pain</li> <li><input type="checkbox"/> Pain killers give moderate relief from pain</li> <li><input type="checkbox"/> Pain killers give very little relief from pain</li> <li><input type="checkbox"/> Pain killers have no effect on the pain and I do not use them</li> </ul>



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PATIENT NAME:	DOB:
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This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by filling in the appropriate box. If you are unsure about how to answer the questions, please provide the best answer you can.

1. Are you male or female? <input type="checkbox"/> Male <input type="checkbox"/> Female			
2. How old were you on <input type="checkbox"/> Less than 35 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75-84 <input type="checkbox"/> 85 or older you last birthday?			
3. In general, how would you say your health is? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
4. Compared to one year ago, how would you rate your health in general now? <input type="checkbox"/> Much better now <input type="checkbox"/> Somewhat better now <input type="checkbox"/> About the same <input type="checkbox"/> Somewhat worse now <input type="checkbox"/> Much worse now than 1 year ago			
5. The following items are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much? (Mark one box at each line)			
	Yes, limited a lot	Yes, limited a little	No, not limited at all
<b>a) Vigorous activities</b> such as running, lifting heavy objects, participating in strenuous sports			
<b>b) Moderate activities</b> such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
<b>c)</b> Lifting or carrying groceries			
<b>d)</b> Climbing <b>several</b> flights of stairs			
<b>e)</b> Climbing <b>one</b> flight of stairs			
<b>f)</b> Bending, kneeling or stooping			
<b>g)</b> Walking <b>more than a mile</b>			
<b>h)</b> Walking <b>several blocks</b>			
<b>i)</b> Walking <b>one block</b>			
<b>j)</b> Bathing or dressing yourself			
6. During the past <b>4 weeks</b> , have you had any of the following problems with your work or other regular daily activities as a result of your <b>physical health</b> ? (Mark one box on each line)			
<b>a)</b> Cut down the <b>amount of time</b> you spent on work activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>b)</b> <b>Accomplished less</b> than you would like	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>c)</b> Were <b>limited in the kind</b> of work or other activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>d)</b> Had <b>difficulty</b> performing the work or other activities (for example, it took extra effort)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. 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)? (Mark one box on each line)			
<b>a)</b> Cut down the <b>amount of time</b> you spent on work activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>b)</b> <b>Accomplished less</b> than you would like	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>c)</b> <b>Didn't do work</b> or other activities as carefully as usual	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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PATIENT NAME:	DOB:					
TIMEPOINT:	DATE:					
8. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal your social activities with family, friends, neighbors or groups: (mark one box) <input type="checkbox"/> Not at all <input type="checkbox"/> Slightly <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely						
9. How much bodily pain have you had in the <b>past 4 weeks</b> ? (mark one box) <input type="checkbox"/> None <input type="checkbox"/> Very Mild <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Very Severe						
10. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (mark one box) <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Moderately <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely						
11. These questions are about how you feel and how things have been with you during the <b>past 4 weeks</b> . For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks did you experience the following? (mark one box on each line)						
	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time
a) Did you feel full of pep?						
b) Have you been a very nervous person?						
c) Have you felt so down in the dumps nothing could cheer you up?						
d) Have you felt calm and peaceful?						
e) Did you have a lot of energy?						
f) Have you felt down-hearted and blue?						
g) Did you feel worn out?						
h) Have you been a happy person?						
i) Did you feel tired?						
12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc) (mark one box) <input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> A little of the time <input type="checkbox"/> None of the time						
13. Please choose the answer that best describes how true or false each of the following statements is for you. (mark one box on each line)						
	Definitely true	Mostly true	Don't know	Mostly false	Definitely false	
a) I seem to get sick a little easier than other people						
b) I am as healthy as any-body I know						
c) I expect my health to get worse						
d) My health is excellent						
14. Have you ever filled out this form before? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't remember						

# Fort Worth Orthopedics

Dr. Mark Wylie • Dr. William Mitchell • Dr. Carson Fairbanks