WEST Sports Medicine & Orthopaedics

Patient Health Questionnaire

Patient Name: **DOB:** **Patient ID:**

Current **employment status**? ❑Occupation _____ ❑Retired ❑Student ❑Disabled

Work activities mostly include: ❑Sitting ❑Standing ❑Walking ❑Lifting ❑Bending ❑Computer ❑Driving ❑Varied

❑Other:_____

How do you **rate your health**? ❑Excellent ❑Good ❑Fair ❑Poor

When did your **current symptoms begin**? (*date*)_____/_____/_____ or (*time period*) _____

Have you experienced these **symptoms before** (please explain)?

Do you currently **exercise, play sports** or **have hobbies** (*if yes, please describe*)?

How did your **injury occur** or **symptoms begin** (*check all that apply*)?

❑ Accident – Work Related	❑ Bending	❑ Reaching	❑ Other:
❑ Accident – Motor Vehicle	❑ Falling	❑ No Apparent Reason	
❑ Accident – Liability / 3rd Party	❑ Lifting	❑ Gradual Onset	

Indicate daily **activities you are having trouble with** due to this injury or onset of symptoms (*check all that apply*)?

❑ Sitting __minutes	❑ Standing ___minutes	❑ Reaching	❑ Dressing
❑ Rising	❑ Turning	❑ Lying	❑ Housework
❑ Bending	❑ Walking ___ feet	❑ Sleeping___ hours	❑ Athletics
❑ Driving	❑ Stairs	❑ Grooming	❑ Other:

What **treatment & testing** have you received (*check all that apply*)?

❑ Physical Therapy	❑ Bracing	❑ Nerve Conduction Study
❑ Occupational Therapy	❑ Orthotics	❑ Myelogram
❑ Chiropractic	❑ X-Ray	❑ Other:
❑ Injection	❑ MRI	
❑ Medication	❑ CT Scan	

If you had **surgery**, list the **type of surgery** _____ and **date of surgery** _____/_____/_____

Do you experience **frequent episodes** of the following (*check all that apply*)?

❑ Headaches ❑ Dizziness ❑ Nausea ❑ Ear Ringing ❑ Balance Control

Have you noticed a change in your **bowel or bladder frequency or control**?

❑ Yes ❑ No If yes, please explain:

Do you have, or have you had, **any of the following** (*check all that apply*)?

	Yes	No		Yes	No	
Asthma	❑	❑	Metal Implants	❑	❑	List additional history:
Cancer	❑	❑	Osteoarthritis	❑	❑	
COPD	❑	❑	Osteoporosis	❑	❑	
Currently Pregnant	❑	❑	Pacemaker	❑	❑	
Diabetes	❑	❑	Peripheral Vascular Disease	❑	❑	
Epilepsy	❑	❑	Previous Surgery	❑	❑	
Heart Condition	❑	❑	Rheumatoid Arthritis	❑	❑	
Hypertension	❑	❑	Stroke History	❑	❑	

Patient Name:	DOB:	Patient ID:

Use the following scales to **rate your average symptom level** (*circle the appropriate level for each body part*).
"0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10 **Arm**: 0 1 2 3 4 5 6 7 8 9 10 **Leg**: 0 1 2 3 4 5 6 7 8 9 10

Neck: 0 1 2 3 4 5 6 7 8 9 10 **Hand**: 0 1 2 3 4 5 6 7 8 9 10 **Foot**: 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below *(reference the KEY)*, **where specifically you feel the pain** indicated above:

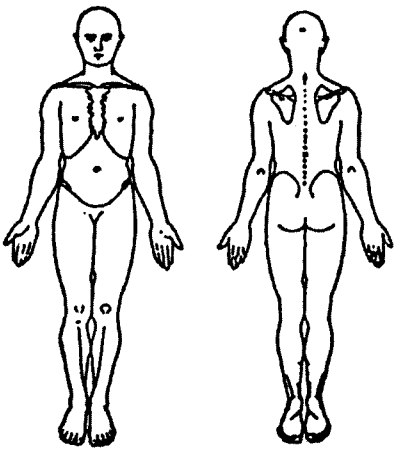
KEY

///// Stabbing

xxxxx Burning

00000 Pins & Needles

_____ Numbness



Do you **take any medications** *(If **Yes**, please fill out below or you may provide a list of your medicines)*:

Prescription Medication	Dosage	Frequency	Medicine Route
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection
			❑ Oral ❑ Injection

Over the Counter Medications *(Please circle any OTC medications that you take regularly)*: Aspirin / Ibuprofen, Antacids, Sleeping Aids, Cold Medicine, Cough Medicine, Allergy Relief, Laxatives, Vitamin/Herbal Supplements, Diet Pills

Do you **have allergies** to ❑ Latex ❑ Lidocaine ❑ Cortisone ❑ None Known ❑Other:

Are you **currently receiving home health** services or have you **within the last 4 weeks**? ❑Yes ❑No

Have you had any physical, occupational or speech therapy **this calendar year**? ❑Yes ❑No

Do you have a **family member** or **friend** who can assist you during your recovery and with your care? ❑Yes ❑No

What **goals** do you have for therapy? What do you **hope to accomplish**?

My **next appointment** with my doctor () is on _____/_____/_____ ❑ No appt scheduled.

Patient Signature:	Date:
Reviewed Health History with Patient:	Date:

Neck Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name / ID: **Date:**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100
(Therapist will calculate)

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

Patient Name / ID: **Date:**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is very severe.
5 The pain is very severe and does not vary much.

Sleeping

0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of pain my normal sleep is reduced by less than 25%.
3 Because of pain my normal sleep is reduced by less than 50%.
4 Because of pain my normal sleep is reduced by less than 75%.
5 Pain prevents me from sleeping at all.

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 more than 1 hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain immediately.

Standing

0 I can stand as long as I want without pain.
1 I have some pain while standing but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases pain immediately.

Walking

0 I have no pain while walking.
1 I have some pain while walking but it doesn't increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than 1/2 mile without increasing pain.
4 I cannot walk more than 1/4 mile without increasing pain.
5 I cannot walk at all without increasing pain.

Patient Name / ID: **Date:**

Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights.

Traveling

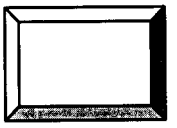
0. I get no pain while traveling.
1. I get some pain while traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except that done while lying down.
5. Pain restricts all forms of travel.

Social Life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Back Index Score(Therapist Will Calculate) = 

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

THE LOWER EXTREMITY FUNCTIONAL SCALE

Patient Name: _____ **Acct Number:** _____ Date: _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit Of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: (Therapist will calculate) _____/ 80

Please submit the sum of responses to ACN.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

DISABILITIES OF THE ARM, SHOULDER AND HAND

Patient Name / ID: **Date:**

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	Open a tight or new jar.	1	2	3	4	5
2.	Write.	1	2	3	4	5
3.	Turn a key.	1	2	3	4	5
4.	Prepare a meal.	1	2	3	4	5
5.	Push open a heavy door.	1	2	3	4	5
6.	Place an object on a shelf above your head.	1	2	3	4	5
7.	Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8.	Garden or do yard work.	1	2	3	4	5
9.	Make a bed.	1	2	3	4	5
10.	Carry a shopping bag or briefcase.	1	2	3	4	5
11.	Carry a heavy object (over 10 lbs).	1	2	3	4	5
12.	Change a lightbulb overhead.	1	2	3	4	5
13.	Wash or blow dry your hair.	1	2	3	4	5
14.	Wash your back.	1	2	3	4	5
15.	Put on a pullover sweater.	1	2	3	4	5
16.	Use a knife to cut food.	1	2	3	4	5
17.	Recreational activities which require little effort (e.g., cardplaying, knitting, etc).	1	2	3	4	5
18.	Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19.	Recreational activities in which you move your arm freely (e.g., playing Frisbee, badminton, etc.).	1	2	3	4	5
20.	Manage transportation needs (getting from one place to another).	1	2	3	4	5
21.	Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

Patient Name / ID: **Date:**

		NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22.	During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? *(circle number)*	1	2	3	4	5

		NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23.	During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? *(circle number)*	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

		NONE	MILD	MODERATE	SEVERE	EXTREME
24.	Arm, shoulder or hand pain.	1	2	3	4	5
25.	Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26.	Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27.	Weakness in your arm, shoulder or hand.	1	2	3	4	5
28.	Stiffness in your arm, shoulder or hand.	1	2	3	4	5

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29.	During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

		STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30.	I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. *(circle number)*	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____
(Therapist will calculate)

([(sum of n responses / n) – 1] x 25, where n is the number of completed responses.)

A DASH score may <u>not</u> be calculated if there are greater than 3 missing items.

FOOT/ANKLE DISABILITY INDEX

Name: _____ **Date:** _____

Please read: This questionnaire has been designed to give the Physical Therapist information as to how your foot/ankle pain has affected your ability to manage everyday live, Please answer by marking the one box which most closely applies to you.

Section 1 — PAIN INTENSITY

_____ I have no pain in my foot/ankle.
_____ The pain in my foot/ankle in intermittent or mild and does not limit my activity.
_____ The pain in my foot/ankle in intermittent, but limits my activity.
_____ The pain in my foot/ankle is constant and moderately limits my activity.
_____ The pain in my foot/ankle is constant and severely limits my activity.
_____ The pain in my foot/ankle is constant and I am unable to do anything.

Section 2 — STANDING

_____ I can stand as long as I want to.
_____ I am able to stand for over 60 minutes before symptoms increase.
_____ I am able to stand 31—60 minutes before symptoms increase.
_____ I am able to stand 11—30 minutes before symptoms increase.
_____ I am only able to stand for very short periods: 10 minutes or less
_____ I am unable to stand for any length of time

Section 3 — WALKING/WEIGHT BEARING TOLERANCE

_____ I can walk normally without assistive devices.
_____ I can walk without assistive devices, but only for 31—60 minutes
_____ I can walk without assistive devices, but only 30 minutes or less
_____ I can walk as far as I need, but I must use assistive devices.
_____ I must use assistive devices and can bear only partial weight on my injured foot.
_____ I must use assistive devices and can bear minimal to no weight on my injured foot.

Section 4 — CLIMBING STAIRS

_____ I am able to go up & down stairs normally.
_____ I am able to go up & down stairs step over step if I go slowly.
_____ I am able to go up & down stairs step over step, but only a limited number at a time.
_____ I am able to go up & down stairs, but only one at a time.
_____ I am able to go up & down a limited number of stairs an only one at a time.
_____ I am unable to use stairs.

Section 5 — SWELLING

_____ I have no swelling with my high level of activity.
_____ I have minimal swelling only after my highest level of activity.
_____ I have no swelling with normal daily activity.
_____ I have minimal swelling after simple activity.
_____ I have almost constant swelling, but it can be controlled by medication/rest/ice/compression/elevation.
_____ I have constant swelling without relief foot/ankle.

Section 6 — WORK

_____ I can do as much work as I want to.
_____ I can do my usual work, but it increases my foot/ankle pain.
_____ I can do most, but not all, of my usual work because of my foot/ankle pain.
_____ I can do about half of my usual work because of foot/ankle pain.
_____ I can only do minimal work because of my foot/ankle pain.
_____ I can't do any work at all because of my foot/ankle pain.

Section 7 — DRIVING

_____ I can drive my car as long as I want without any foot/ankle pain.
_____ I can drive my car as long as I want, but it increases pain in my foot/ankle.
_____ I can drive my car 31-60 minutes before my foot/ankle pain gets worse.
_____ I can drive my car 11-30 minutes before my foot/ankle pain gets worse.
_____ I can drive my car for only 10 minutes or less before my foot/ankle pain gets worse.
_____ I am unable to drive my car because of my foot/ankle pain.

Section 8 — SLEEPING

_____ I have no trouble sleeping.
_____ My sleep is slightly disturbed by foot/ankle pain. (It wakes me 1 time/night).
_____ My sleep is mildly disturbed by foot/ankle pain. (It wakes me 2 times/night).
_____ My sleep is moderately disturbed by foot/ankle pain (It wakes me 3-4 times/night).
_____ My sleep is greatly disturbed by foot/ankle pain (It wakes me 5-6 times/night).
_____ My sleeps is completely disturbed by foot/ankle pain (It wakes 7-8 times/night or more).

Section 9 — HOUSE & YARD WORK

_____ I have no foot/ankle limitations with house & yard work.
_____ I am able to do all house & yard work necessary if I take a few breaks.
_____ I am able to do all house & yard work necessary, but it increases my foot/ankle pain.
_____ I am able to do some, but not all, house & yard work, in increases my foot/ankle pain.
_____ I am able to do only the minimum of house & yard work because of my foot/ankle pain.
_____ I am unable to do any house or yard work because of my foot/ankle pain.

Section 10 — RECREATION/SPORTS

_____ I am able to engage in all my recreation/sports activities with not foot/ankle symptoms.
_____ I am able to engage in all my recreation/sports activities with some symptoms in my foot/ankle.
_____ I am able to engage in most, but not all, of my usual recreation/sports activities because of symptoms in my foot/ankle.
_____ I can hardly do any recreation/sports activities because of symptoms in my foot/ankle.
_____ I am unable to do any recreation/sports activities because of my symptoms.

Please mark an "x" on the line below indicating the level of pain you have had in the past 24 hours.

no pain at all ——————————————————— worst possible pain _____/50= _____%