DR. WANG HISTORY FORM

NAME: _____ **AGE:** _____

☐ Right ☐ Left Handed ☐ Male ☐ Female Height ____ft ____ in Weight _____

Date of Injury _____ Date of this Examination _____

WORK (JOB) HISTORY

Employer at time of injury _____ City of Employment _____

Date Hired _____ Job Title _____

Job duties at the time of injury/illness _____

Did you do any lifting? ☐ Yes ☐ No

Heaviest weight lifted was _____ pounds _____ times per hour _____hours per day_____

Did you do any keyboarding (computer, typing, mouse)? ☐ Yes ☐ No

How many minutes per hour _____ and how many hours per day _____

Did you do any task (work) rapidly or repetitively (over and over)? ☐ Yes ☐ No.

Explain _____

_____

How often: _____Time per hour _____Times per day _____Times per week

Did you do any: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Kneeling ☐ Squatting ☐ Bending ☐ Crawling
☐ Pushing ☐ Pulling ☐ Climbing
☐ Reaching above shoulder level

Work on: ☐ Ladders ☐ Scaffolding ☐ Roofs Other _____

Hours worked per day _____ Days worked per week_____ Total hours worked per week_____

When hired did you have any restrictions? ☐ No ☐ Yes If yes, please explain _____

_____

_____

PAST WORK HISTORY

Where have you worked prior to the job you were injured on?

Prior Employer	Duties	Date Started	Date Ended

At the time of your injury, were you working two jobs? ☐ No ☐ Yes If yes, please describe

Name of Employer	Duties	Date Started	Date Ended
	Hours per day: Hours per week:		

CURRENT WORK STATUS

Are you working now? ☐ No ☐ Yes If yes, working for the same employer where injury occurred? ☐ Yes ☐ No

If working for the same employer, did you ever stop? ☐ No ☐ Yes If yes, date stopped _____

If working for the same employer, are you doing the same job you did when you were injured? ☐ No ☐ Yes

If no, please explain: _____

Are you working with any restrictions or limitations? ☐ No ☐ Yes Explain: _____

_____

Are you working for a different employer? ☐ No ☐ Yes If yes, name of employer _____

Job Title/Duties _____ Date Started _____

Do you have any job restrictions or limitations? ☐ No ☐ Yes Explain: _____

_____

DATE STOPPED WORKING FOR EMPLOYER WHERE INJURED: _____ Why did you stop? ____

_____

Have you had employment with other employers since your injury? ☐ No ☐ Yes If yes, please describe:

Employer	Duties	Date Started	Date Ended	Why did you stop?

Since the injury, were you off work any time ☐ No ☐ Yes Days_____ Weeks_____ Months_____

Since your injury, have you worked with restrictions or modifications on any job at any time? ☐ No ☐ Yes

Explain: _____ Dates: From _____ To _____

VOCATIONAL REHABILITATION – JOB RETRAINING

Have you had any job retraining? ☐ No ☐ Yes ☐ Or contacted about retraining?

For what job (occupation) _____

Date started or expected to start _____ Date ended or expected to end _____

HISTORY OF PRESENT INJURY

Date of Injury_____ Place of Injury_____ Time of Injury_____ am/pm

Shift (working hours) on date of injury. Start _____ am/pm End_____ am/pm

Describe the injury. What were you doing? How did it occur? What part or parts of the body were hurt?

_____

_____

Did you stop work or modify your activities immediately after the injury? ☐ No ☐ Yes If yes, explain

_____

Did you report your injury? ☐ No ☐ Yes If yes, to whom? _____

Following your injury, did you do any self-treatment? ☐ No ☐ Yes Heat, ice rest, medicine, other _____

When did you first receive medical treatment? Date_____ Time_____ Never ☐

Following your injury, what treatment did you receive? None ☐

Were you ever denied medical treatment? ☐ No ☐ Yes If yes, please explain what treatment was denied:_____

Medication: ☐ No ☐ Yes What medication? _____

☐ Brace – Neck/Back ☐ Splints – Arm/Wrist ☐ Supports – Elbow/Wrist/Knee/Ankle

☐ Cast ☐ Sling ☐ Cane ☐ Crutches ☐ Walker Other _____

Where did you receive treatment? ☐ None ☐ Company doctor ☐ Emergency room ☐ Chiropractor

☐ Family doctor ☐ Walk-in clinic ☐ Other – Name _____ City/State_____

I received the following tests after y injury:

☐ X-rays of _____ ☐ Nerve test: EMG/NCS - arms or legs

☐ CT scan of _____ ☐ Blood/urine testing

☐ MRI of _____ ☐ Other _____

Were you admitted to the hospital? ☐ No ☐ Yes If yes, what hospital _____

How long did you stay? _____ Did you have surgery ☐ No ☐ Yes If yes, date of surgery _____

Explain what was done: _____

FOLLOW-UP CARE

I had follow-up care: ☐ No ☐ Yes Treatment dates: _____ Times per Week _____ Months _____

Physical therapy: ☐ No ☐ Yes Treatment dates: _____ Times per Week _____ Months _____

Chiropractic: ☐ No ☐ Yes Treatment dates: _____ Times per Week _____ Months _____

Injections: ☐ No ☐ Yes Treatment dates: _____ Times per Week _____ Months _____

Surgery: ☐ No ☐ Yes Treatment dates: _____ Times per Week _____ Months _____

Other – Explain: _____

☐ Cane ☐ Crutches ☐ Walker ☐ Braces for back/neck ☐ Splints for arm/leg

☐ Supports for elbow, wrist, knee, ankle ☐ Sling ☐ Cast ☐ Other _____

PAST HISTORY

Prior to the injury in question, have you ever had similar problems with injuries to the body part or parts involved in this claim? ☐ No ☐ Yes If yes, give details:

Date of injury	Work-related?	Body parts	Treatment
	☐ No ☐ Yes		
	☐ No ☐ Yes		
	☐ No ☐ Yes		

Did you get completely well? ☐ Yes How long did it take? _____

☐ No Were you having problems at the time of the injury in question?

If yes, explain:_____

Have you had any other <u>work</u> or <u>non-work</u> injuries *since* the injury involved in this claim? ☐ No ☐ Yes

If yes, explain:_____

Date of injury: _____ How did injury occur; work; non-work; body parts, treatment_____

_____

Did you get completely well? ☐ Yes How long did it take? _____

☐ No If no, explain: _____

Have you ever had an auto accident/motor vehicle accident? ☐ No ☐ Yes If yes, explain:

Date of injury	Body parts	Treatment	Did you get completely well?

Have you had any other non-work serious accidents, sports injuries or illnesses? ☐ No ☐ Yes

Explain: _____

Have you had a prior work injury to any part of your body different from the body part involved in this claim?

☐ No ☐ Yes If yes, explain _____

Have you ever received a permanent disability settlement? ☐ No ☐ Yes

If yes, give dates and settlement _____ Explain – Percentage/amount/body parts involved:

_____

Do you have adult illnesses?			Current treatment/medications
High blood pressure	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Heart disease	☐ No	☐ Yes	
Lung disease	☐ No	☐ Yes	
Cancer	☐ No	☐ Yes	
Other			

Have you had surgery? ☐ No ☐ Yes

Date of surgery	Type and body part of surgery	Results of surgery

Have you had any non-surgical hospital admissions (including childbirth)? ☐ No

Explain _____

_____

SOCIAL HISTORY

Do you use:	Type	Amount	Past use
Alcohol ☐ No ☐ Yes			☐ No ☐ Yes
Circle: coffee tea ☐ No ☐ Yes		___ Cups per day/week	☐ No ☐ Yes
Drugs: ("Pot" etc.) ☐ No ☐ Yes			☐ No ☐ Yes
Tobacco ☐ No ☐ Yes	Cigarettes cigars Chewing tobacco		☐ No ☐ Yes
Other			

Prior to the injury in question, did you participate in any outdoor or recreational activities? ☐ No ☐ Yes

☐ Gardening ☐ Sewing ☐ Arts/Crafts ☐ Cooking ☐ Computer ☐ Sports ☐ Hiking

☐ Biking ☐ Hunting ☐ Fishing ☐ Golf ☐ Tennis ☐ Softball ☐ Basketball

☐ Soccer ☐ Dancing ☐ Skiing ☐ Walking ☐ Water Sports

Other _____

Are you able to participate in any of these activities now? ☐ No ☐ Yes If yes, which activities? _____

_____

CURRENT TREATMENT

Are you receiving treatment now? ☐ No ☐ Yes If no, give date of last treatment: _____

With doctor, chiropractor, PT, Other –
Name: _____

Date of next visit _____

Are you taking medication now? ☐ No ☐ Yes

Medication name	Purpose of meds (pain, sleep, etc.)	Strength or dose and times taken daily

Does your treatment help? ☐ No ☐ Yes ☐ A little ☐ A lot
Does your medication help? ☐ No ☐ Yes ☐ A little ☐ A lot

FAMILY HISTORY

	Age	**Alive?**		**Diabetes?**		**Heart Disease?**		**Cancer? If yes, what type?**		
		Yes	No	Yes	No	Yes	No	Yes	No	Type
Father										

Mother										
Brother(s)										
Sister(s)										

PRESENT COMPLAINTS

Are you still having pain? ☐ No ☐ Yes If yes, where? _____

☐ Neck ☐ R ☐ L ☐ Shoulder/scapulae/arms ☐ R ☐ L ☐ Elbows/forearms ☐ R ☐ L

☐ Upper back/mid back ☐ R ☐ L ☐ Lower back ☐ R ☐ L ☐ Wrists/hands/fingers ☐ R ☐ L

☐ Pelvis/hips ☐ R ☐ L ☐ Knees/legs ☐ R ☐ L ☐ Ankles/feet/toes ☐ R ☐ L

☐ Headaches ☐ R ☐ L ☐ Other _____

If the pain radiates, where does it travel from (what body part) _____

to (what body part) _____ ☐ R ☐ L

Do you have: Numbness Tingling Burning

If yes, where? What body part? _____ ☐ R ☐ L

If the numbness, tingling and burning travels, where does it go from (what body part) _____

to (what body part) _____

What is the character of pain? (Circle) Dull Stabbing Cramping Sharp Throbbing

Shooting Aching Burning Other

_____

Intensity of pain with 0 no pain and 10 greatest pain.

Mild	Medium	Great
1-3 _____	4-7_____	8-10_____

Frequency of pain _____ _____ _____

Once in a while Off and on All the time

Do you have:

Stiffness ☐ No ☐ Yes Where? _____

Grating/grinding ☐ No ☐ Yes Where? _____

Locking ☐ No ☐ Yes Where? _____

Swelling ☐ No ☐ Yes Where? _____

Snapping/popping ☐ No ☐ Yes Where? _____

Do you have weakness in any joints or muscles? ☐ No ☐ Yes Where? _____

_____

Do you have any giving way of joints? ☐ No ☐ Yes Where? _____

Falling? ☐ No ☐ Yes How many times in the last six months? _____

Does the pain and/or numbness, tingling or burning in your hands, fingers, other _____ awaken you from sleep? ☐ No ☐ Yes If yes, how many times per night _____ How many days per week _____

Do you have full range of motion of your joints? ☐ No ☐ Yes

What joints are limited? ☐ Neck ☐ Shoulders ☐ Elbows ☐ Wrists ☐ Hands ☐ Fingers
☐ Back ☐ Hips ☐ Knees ☐ Ankles ☐ Toes ☐ Other _____

What makes the pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Stooping ☐ Twisting
☐ Lifting ☐ Pushing ☐ Pulling ☐ Repetitive hand motions ☐ Lifting arms overhead
☐ Grasping tightly ☐ Climbing ☐ Kneeling ☐ Bending ☐ Other _____

What makes the pain better? ☐ Nothing ☐ Physical therapy ☐ Chiropractic
☐ Water therapy ☐ Acupuncture ☐ Medications ☐ Injections ☐ Surgery
☐ Braces for neck/back ☐ Supports for elbows/wrists/knees/ankles ☐ TENS unit ☐ Pain patches
☐ Changing positions ☐ Lying down ☐ Getting off feet ☐ Gym/exercise ☐ Resting
☐ Using a cane ☐ Using crutches ☐ Avoiding those positions and activities that make the pain worse
☐ Other_____

Do you lose control of bladder (urine) or bowels (stools)? ☐ No ☐ Yes

Other bowel or bladder problems? _____

Activities of Daily Living (For each question below, please check "Yes" or "No.")

Do you experience any difficulties or limitations feeding yourself? ☐ No ☐ Yes

Do you experience any difficulties or limitations bathing yourself? ☐ No ☐ Yes

Do you experience any difficulties or limitations grooming yourself? ☐ No ☐ Yes

Do you experience any difficulties or limitations dressing yourself? ☐ No ☐ Yes

Do you experience any difficulties with bowel or bladder function (urgency, control, telling when you need to "go")? ☐ No ☐ Yes

Do you experience any difficulties or limitations with sexual function? ☐ No ☐ Yes

Do you experience any difficulties or limitations with sitting? ☐ No ☐ Yes

Do you experience any difficulties or limitations with transferring positions (from bed to chair, sitting to standing, etc.)? ☐ No ☐ Yes

Do you experience any difficulties or limitations with standing? ☐ No ☐ Yes

Do you experience any difficulties or limitations with walking? ☐ No ☐ Yes

Do you require the use of any assistive devices (cane, crutch, walker, etc.)? ☐ No ☐ Yes

Do you experience any difficulties or limitations negotiating stairs? ☐ No ☐ Yes
Do you require the use of a handrail? ☐ No ☐ Yes

Do you experience any difficulties or limitations with communication (writing, typing, speaking, listening, etc.)? ☐ No ☐ Yes

Do you experience any difficulties or limitations with sensory function (hearing, seeing, feeling, tasting, or smelling)? ☐ No ☐ Yes

Do you experience any difficulties or limitations with hand activities (gripping, grasping, twisting, sensation, use of fingers, etc.)? ☐ No ☐ Yes

Do you experience any difficulties or limitations with sleep (change in your pattern of sleep or your ability to sleep)? ☐ No ☐ Yes

Do you experience any difficulties or limitations with travel (driving or riding in a car, plane, etc.)?
☐ No ☐ Yes

Do you experience any difficulties or limitations performing housework? ☐ No ☐ Yes

Do you experience any difficulties or limitations performing yard work? ☐ No ☐ Yes

Do you experience any difficulties or limitations with cooking? ☐ No ☐ Yes

Do you experience any difficulties or limitations with recreational activities? ☐ No ☐ Yes

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

PAIN DRAWING

Complete this drawing for your symptoms at this time (not for symptoms you used to have).

Using the key below, describe your present complaints

Major pain: XXXXX Tingling: YYYYY

Burning: ZZZZZ Secondary pain: /////

Loss of sensation: OOOOO

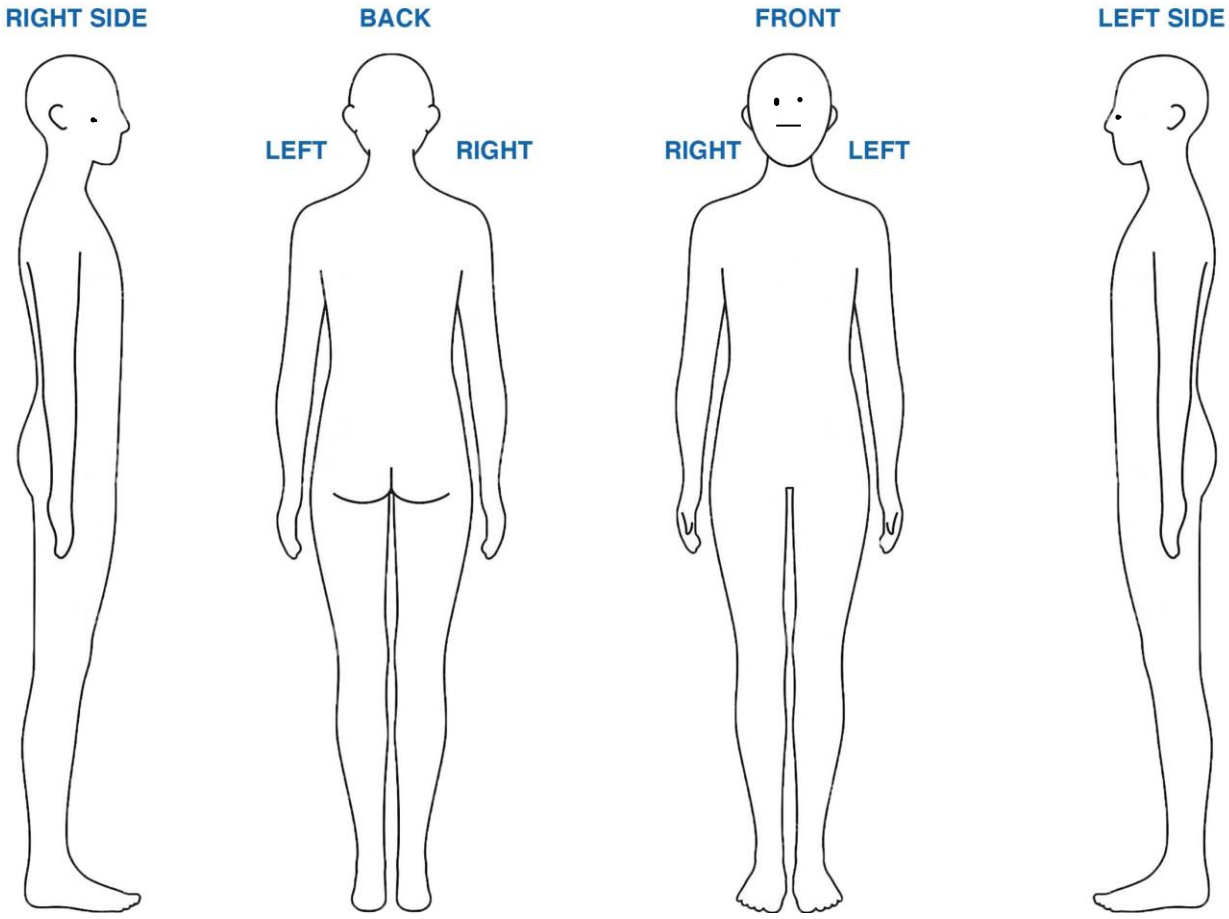

Table 18-4 Ratings Determinating Impairment Associated With Pain **(Circle a Number)**

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment.**

0 1 2 3 4 5 6 7 8 9 10
No pain — Most severe pain

B. Rate how severe your pain is **at its worst**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Excruciating

C. Rate how severe your pain is **on the average**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Excruciating

D. Rate how much your pain is **aggravated by activity.**

0 1 2 3 4 5 6 7 8 9 10
Does not aggravate — Excruciating

Sum Score of Section I: A-D = Total pain severity/4= _____

E. Rate how frequently you experience pain.

0 1 2 3 4 5 6 7 8 9 10
Rarely — All of the time

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block?**

0 1 2 3 4 5 6 7 8 9 10
Does not restrict — Impossible to walk

B. How much does your pain prevent you from **lifting 10 pounds**?

0 1 2 3 4 5 6 7 8 9 10
Does not prevent — Impossible to lift

C. How much does your pain interfere with your ability to **sit for 1/2 hour?**

0 1 2 3 4 5 6 7 8 9 10
Does not restrict — Impossible to sit

D. How much does your pain interfere with your ability to **stand for 1/2 hour?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere at all — Unable to stand

E. How much does your pain interfere with your ability to **get enough sleep?**

0 1 2 3 4 5 6 7 8 9 10
Does not prevent — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely unable

H. In general, how much does your pain interfere with your **daily activities?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

II. Activity Limitation or Interreference (continued)

I. How much do you **limit your activities to prevent your pain from getting worse?**

0 1 2 3 4 5 6 7 8 9 10
Does not limit l — Completely limits

J. How much does your pain interfere with your **relationship with your family/partner/significant others?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

K. How much does your pain interfere with your ability to do **jobs around your home?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely unable

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere at all — Impossible to shower/bathe

M. How much does your pain interfere with your ability to **write or type?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere at all — Impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere at all — Impossible to dress self

O. How much does your pain interfere with your ability to **engage in sexual activities?**

0 1 2 3 4 5 6 7 8 9 10
Does not interfere at all — Almost impossible to engage in sexual activity

P How much does your pain interfere with your ability to **concentrate?**

0 1 2 3 4 5 6 7 8 9 10
Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood.

A. Rate your **overall mood** during the past week

0 1 2 3 4 5 6 7 8 9 10
Extremely high/goo Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10
Not anxious Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain?

0 1 2 3 4 5 6 7 8 9 10
Not depressed at all Extremely depressed

D. During the past week, how **irritable** have you been because of your pain>

0 1 2 3 4 5 6 7 8 9 10
Not irritable at all Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse?**

0 1 2 3 4 5 6 7 8 9 10
Not anxious/worried Extremely anxious/worried

Sum score of Section III:
A-E = total pain impairment attributable to mood state/5 =
Mean score = _____

The Neck Disability Index: Complete this form if your neck is being evaluated.

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 condition.

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 worse imaginable at the moment.

SECTION 2 - PERSONAL CARE (Wash , Dress , etc.)
- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed. I 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 light to medium weights if they are conveniently positioned, for example 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 very light weights.
- ☐ I cannot lift or carry anything at all because of my neck.

SECTION 4 - READING
- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want with moderate neck pain.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all because of my neck.

SECTION 5 - HEADACHES
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty because of my neck.
- ☐ I have a fair degree of difficulty concentrating when I want to because of my neck.
- ☐ I have a lot of difficulty concentrating when I want because of my neck.
- ☐ I have a great deal of difficulty concentrating when I want to because of my neck.
- ☐ I cannot concentrate at all because of my neck.

SECTION 7 - WORK
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work because of my neck.
- ☐ I can hardly do any work at all because of my neck.
- ☐ I can't do any work at all because of my neck.

SECTION 8 - DRIVING
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - SLEEPING
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SEC11ON 10- RECREATION
- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all because of my neck.

Please mark on the line to indicate the amount of neck pain you have had in the past 24 hours.

No pain at all ——————————————————— Worst pain possible

Score _____/50 _____%

Complete this if your mid-back (thoracic) or low back (lumbar) is being evaluated.

OSWESTRY DISABILITY INDEX 2.0

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer *every* section. Circle *only one item in each section* that most closely describes you *today*.

Section 1 – Pain Intensity A. I have no pain at the moment B. The pain is very mild at the moment C. The pain is moderate at the moment D. The pain is fairly severe at the moment E. The pain is very severe at the moment F. The pain is the worst imaginable at the moment	**Section 6 – Standing** A. I can stand as long as I want without extra pain B. I can stand as long as I want but it gives me extra pain C. Pain prevents me from standing for more than 1 hour D. Pain prevents me from standing for more than 1/2 hour E. Pain prevents me from standing for more than 10 minutes F. Pain prevents me from standing at all
Section 2 – Personal Care (washing, dressing, etc.) A. I can look after myself normally without extra pain B. I can look after myself normally but it is very painful C. It is painful to look after myself and I am slow and careful D. I need some help but manage most of my personal care E. I need help everyday in most aspects of self care F. I do not get dressed, wash with difficulty and stay in bed	**Section 7 – Sleeping** A. My sleep is never disturbed by pain B. My sleep is occasionally disturbed by pain C. Because of pain, I have less than 6 hours of sleep D. Because of pain, I have less than 4 hours of sleep E. Because of pain, I have less than 2 hours of sleep F. Pain prevents me from sleeping at all
Section 3 - Lifting A. I can lift heavy weights without extra pain B. I can lift heavy weights, but it causes extra pain C. Pain prevents me from lifting heavy weights off the floor D. Pain prevents me from lifting heavy weights but I can manage light/medium weights if they are conveniently positioned E. I can only lift very light weights at the most F. I cannot lift or carry anything at all	**Section 8 - Sex Life** A. My sex life is normal and causes me no extra pain B. My sex life is normal, but causes some extra pain C. My sex life is nearly normal but is very painful but I can manage if they are conveniently positioned D. My sex life is severely restricted by pain E. My sex life is nearly absent because of pain F. Pain prevents any sex life at all
Section 4 - Walking A. Pain does not prevent me from walking any distance B. Pain prevents me from walking more than 1 mile C. Pain prevents me from walking more than 1/4 mile D. Pain prevents me from walking more than 100 yards E. I can only walk while using a stick or crutches F. I am in bed most of the time and have to crawl to the toilet	**Section 9 - Social Life** A. My social life is normal and causes me no extra pain B. My social life is normal, but increases the degree of pain C. Pain has no significant effect on my social life apart from limiting my more energetic interests (sports, etc.) D. Pain has restricted my social life and I do not go out as often E. Pain has restricted my social life to home F. I have no social life because of the pain
Section 5 - Sitting A. I can sit in any chair as long as I like B. I can only sit in my favorite chair as long as I like C. Pain prevents me from sitting more than 1 hour D. Pain prevents me from sitting more than 1/2 hour E. Pain prevents me from sitting more than 10 minutes F. Pain prevents me from sitting at all	**Section 10 – Traveling** A. I can travel anywhere without pain B. I can travel anywhere but it causes extra pain C. Pain is bad but I manage journeys over 2 hours D. Pain restricts me to journeys of less than 1 hour E. Pain restricts me to short necessary journeys under 30 min. F. Pain prevents me from traveling except to receive treatment

SCORE _____

FEAR AVOIDANCE BELIEF QUESTIONNAIRE

For each statement, please circle the number from 0 to 6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your pain, even if you currently don't have back pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6
3. Physical activity might harm my back.	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain. **(Circle an answer even if you currently don't have back pain).**

	Completely Disagree			Unsure			Completely Agree
6. My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
7. My work aggravated my pain.	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain.	0	1	2	3	4	5	6
9. My work is too heavy for me.	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6
11. My work might harm by back.	0	1	2	3	4	5	6
12. I should not do my regular work with my present pain.	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work.	0	1	2	3	4	5	6