UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER
SPINE INSTITUTE

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Please complete all pages of the form in blue/black ink.

Name: _____ Age:_____ Date: _____

1. Reason for visit today
   - ☐ Routine post operative follow-up visit (date of surgery_____)
   - ☐ Review ordered test
   - ☐ Evaluate progress of therapy/injection
   - ☐ Discuss continuing problem
   - ☐ Other: _____
2. Please indicate on the line below how bad your pain is now.

   No Pain ----------Worst Possible Pain
   0 10

3. ☐ Current problem unchanged from last visit on _____ (date).
   ☐ Current problems changed from last visit on _____ (date).

   Describe changes: _____
   _____
   _____

4. What medication(s) and how much (either prescription or over the counter) are you currently taking for this pain?

   _____

   _____

   Pharmacy: _____ Number: _____

5. How many sessions of physical therapy have you had since your last visit? _____ ☐ N/A
6. How many injections have you had since your last visit? _____ ☐ N/A
7. Medical History (including illness, surgery, and medications) are:

   ☐ Unchanged ☐ Changed from last visit on _____ (date).

   Describe Changes _____

   _____
8. Are you currently working? ☐ Yes ☐ No
9. Check any allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Morphine ☐ Demerol
   ☐ Codeine ☐ Arthritis Drugs ☐ Anesthesia Problems ☐ Latex Allergy
   ☐ Other (list) _____
10. Do you smoke cigarettes now? ☐ Yes ☐ No

    If yes, how much: _____ packs per day for _____ years

If you smoked in the past, how long has it been since you stopped? _____

Patient Name:_____

This questionnaire asks for your views about your general health. This information will help keep track of how you are feeling and how well you are able to do your usual activities. For each of the following questions, please mark with an "X" in the one box that best describes your answer. Please do not skip any questions.

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

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

   ☐ Much better now than ☐ Somewhat better than 1 year ago
   ☐ About the same as 1 year ago ☐ Somewhat worse now than 1 year ago
   ☐ Much worse now than 1 year ago

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

	Yes Limited a lot	Yes Limited a little	Yes Not limited at all
a. Vigorous activities, such as running, lifting, heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than one mile	☐	☐	☐
h. Walking several blocks	☐	☐	☐
i. Walking one block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

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

	Yes	No
a. Cut down the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kid of work or other activities	☐	☐
d. Had difficulty performing the work or other activities (e.g. it took extra effort)	☐	☐

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

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kind of work or other activities	☐	☐
d. Had difficulty preforming the work or other activities (for example, it took extra effort	☐	☐

Patient Name:_____ **Date:** _____

Neck Disability Index

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

Section 1: Pain Intensity

☐ I can tolerate the pain I have without having to use painkiller.
☐ The pain is bad, but I manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself but I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need some 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 causing 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, e.g., 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: Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐I can read as much as I want with moderate pain in my neck.
☐ I cannot read as much as I want because of moderate pain in my neck.
☐ I cannot read as much as I want because of severe pain in my neck.
☐ I cannot read at all.

Section 5: Sitting

☐ 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
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I have a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty concentrating when I want to
☐ I cannot concentrate at all

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 usual work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I can't do any work at all

Section 8: Driving

☐ I can drive my car without 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 pain in my neck
☐ I can hardly drive at all because of severe pain in my neck
☐ I cant 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)

Section 10: Recreation

☐ I am able to engage in all recreation activities with no pain in my neck at all
☐ I am able to engage in all recreation activities with some pain in my neck
☐ I am able to engage in most, but not all recreational activities because of pain in my neck
☐ I am able to engage in few of my usual recreational activities because of pain in my neck
☐ I can hardly do any recreational activities because of pain in my neck
☐ I cant do any recreation activities at all

Score:_____

This spine follow-up form has been reviewed by:_____ **MD/NP/PA Date:**_____