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| Teodoro P. Nissen, M.D., Q.M.E. | Joseph M. Centeno, M.D. |
| Fellowship Trained | Fellowship Trained |
| Board Certified | Board Certified |

**PATIENT INFORMATION SHEET**

# **TEODORO NISSEN, M.D.**

TODAYS DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MI DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP

HOME PHONE ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU \_\_\_\_\_ LEFT OR \_\_\_\_\_ RIGHT HANDED

**TEODORO NISSEN, M.D.**

PLEASE PRINT:

1. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_\_

DOMESTIC STATUS: **S M D Sep W Live With** HANDED: **R L** SEX: **M F**

CITY (LIVE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY (WORK): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: \_\_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_

1. Are you working now? Y N If yes, is it **FULL DUTY** or **WITH RESTRICTIONS**

List restrictions, if any.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, is it because of an injury? **Y N** If yes, when was the injury?

Do you have a medical excuse to be off work? Y N

Do you receive disability payments? **Y N** If yes, is it from **Work Comp State SSI**

If you are not working, what is the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was last date worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Who is your present (or most recent) employer?

Type of company Date hired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Days worked per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe what you do at your job \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete the chart below, indicating how often you perform the various activities described in your usual work day at the job you do now.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Up to 1/3 of the day | Up to 2/3 of the day | Over 2/3 of the day |
| Sit in Chair……………… | ( ) | ( ) | ( ) | ( ) |
| Type/Keyboard…………. | ( ) | ( ) | ( ) | ( ) |
| Drive……………………. | ( ) | ( ) | ( ) | ( ) |
| Stand in one place………. | ( ) | ( ) | ( ) | ( ) |
| Walk…………………… | ( ) | ( ) | ( ) | ( ) |
| Walk on Uneven Ground... | ( ) | ( ) | ( ) | ( ) |
| Climb…………………… | ( ) | ( ) | ( ) | ( ) |
| Grip……………………….. | ( ) | ( ) | ( ) | ( ) |
| Reach………………….. | ( ) | ( ) | ( ) | ( ) |
| Reach Overhead…………. | ( ) | ( ) | ( ) | ( ) |
| Twist………………… | ( ) | ( ) | ( ) | ( ) |
| Stoop………………….. | ( ) | ( ) | ( ) | ( ) |
| Bend…………………... | ( ) | ( ) | ( ) | ( ) |
| Squat…………………. | ( ) | ( ) | ( ) | ( ) |
| Crawl…………………... | ( ) | ( ) | ( ) | ( ) |
| Push/Pull………………... | ( ) | ( ) | ( ) | ( ) |
| Kneel…………………. | ( ) | ( ) | ( ) | ( ) |
| Lift < 10 pounds……….. | ( ) | ( ) | ( ) | ( ) |
| Lift 10-25 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 25-50 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 50-75 pounds……….. | ( ) | ( ) | ( ) | ( ) |
| Lift 75-100 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 100 pounds…………. | ( ) | ( ) | ( ) | ( ) |

1. If you hold (or, at the time of injury held) more than one job, list the others:

Name of employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Employer at time of injury (if different than #3 above):

Name City

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date you started work there Date you last worked there\_\_\_\_\_\_\_\_\_\_\_\_\_

Why you left (laid off, fired, voluntary)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could you do this job now? \_\_\_\_\_\_\_If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF THE EMPLOYER, WHEN YOU WERE INJURED, IS NOT WHERE YOU WORK NOW, PLEASE COMPLETE THIS DESCRIPTION OF THE JOB WHICH YOU WERE DOING AT THE TIME YOUR INJURY HAPPENED.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Up to 1/3 of the day | Up to 2/3 of the day | Over 2/3 of the day |
| Sit in Chair……………… | ( ) | ( ) | ( ) | ( ) |
| Type/Keyboard…………. | ( ) | ( ) | ( ) | ( ) |
| Drive……………………. | ( ) | ( ) | ( ) | ( ) |
| Stand in one place………. | ( ) | ( ) | ( ) | ( ) |
| Walk…………………… | ( ) | ( ) | ( ) | ( ) |
| Walk on Uneven Ground... | ( ) | ( ) | ( ) | ( ) |
| Climb…………………… | ( ) | ( ) | ( ) | ( ) |
| Grip……………………….. | ( ) | ( ) | ( ) | ( ) |
| Reach………………….. | ( ) | ( ) | ( ) | ( ) |
| Reach Overhead…………. | ( ) | ( ) | ( ) | ( ) |
| Twist………………… | ( ) | ( ) | ( ) | ( ) |
| Stoop………………….. | ( ) | ( ) | ( ) | ( ) |
| Bend…………………... | ( ) | ( ) | ( ) | ( ) |
| Squat…………………. | ( ) | ( ) | ( ) | ( ) |
| Crawl…………………... | ( ) | ( ) | ( ) | ( ) |
| Push/Pull………………... | ( ) | ( ) | ( ) | ( ) |
| Kneel…………………. | ( ) | ( ) | ( ) | ( ) |
| Lift < 10 pounds……….. | ( ) | ( ) | ( ) | ( ) |
| Lift 10-25 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 25-50 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 50-75 pounds……….. | ( ) | ( ) | ( ) | ( ) |
| Lift 75-100 pounds………. | ( ) | ( ) | ( ) | ( ) |
| Lift 100 pounds…………. | ( ) | ( ) | ( ) | ( ) |

1. Previous employers:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Put your symptoms from this injury in order (from the main one to least), tell me how often it's

present (i.e., constant; most of the time; comes and goes; not every day; not every week, etc.), and what makes it better/worse.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | SYMPTOM | HOW OFTEN | BETTER | WORSE |
| (MAIN SYMPTOM) |  |  |  |  |
| (NEXT IMPORTANT) |  |  |  |  |
| (NEXT IMPORTANT) |  |  |  |  |
| (NEXT IMPORTANT) |  |  |  |  |
| (NEXT IMPORTANT) |  |  |  |  |

### Do you take medicine for your symptoms? If so, tell me what/how often.

**NO YES**

Do you use any brace, support, appliance, walking assistive device? If so, tell me what.

**NO YES**

**AT THIS TIME**

How long can you drive before having to stop/get out?

How long can you sit before having to stand up?

How long can you stand in one place before sitting/moving around?

How long can you walk?

How much can you lift on a regular basis?

Can you shop for groceries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carry them?

Can you clean your house? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEFORE THIS INJURY**

How long can you drive before having to stop/get out? \_\_\_\_\_\_\_\_\_

How long can you sit before having to stand up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long can you stand in one place before sitting/moving around? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long can you walk? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much can you lift on a regular basis? \_

Can you shop for groceries? \_\_\_\_\_\_\_\_ Carry them?

Can you clean your house? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been involved in a lawsuit or legal action related to injury or health matters before this injury?

**NO YES (describe):**

Use these symbols to show where your symptoms are.

Major pain:

Secondary pains: Loss of Sensation:

KEY:

XXX

///

000

Tingling: YYY

Burning:

ZZZ

RIGHT LEFT LEFT RIGHT



1. Tell me about the injury or injuries (approximate dates are fine) that caused your current symptoms.

Date(s) of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date you reported it to employer: \_\_\_\_\_\_\_\_\_

Date you first got treatment \_\_\_\_\_\_\_\_\_\_\_\_Date of your last treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates you were off work Dates you were on restricted work

From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_ From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_

From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_ From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_

From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_ From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_

From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_ From \_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_

How did the injury happen?

What body parts were involved initially?

How much better are you? 100% 75% 50% 25% None Worse

Did you ever have an injury or problem with this/these body parts

before the injury? **NO YES**

Have you had any injury to this/these body parts

since the injury? **NO YES**

9. Tell me about the treatment for your injury.

Name of Treater Type of Treatment From To How much it helped

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. What tests have been done:

**X-ray Myelogram CT Scan MRI Scan Bone scan**

**EMG/Nerve test Blood test Urine Test Psychological test**

**Other**

11. What were your leisure time activities before this injury? (hobbies, sports, recreation)

Describe any changes in these activities because of the injury you sustained:

12. What other medicine, besides listed in #7 do you take?

Are you allergic to any medicine?

13. If there is a history of medical problems in you or your family, please list:

Who (i.e., Self, Mother, Father) Condition

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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14. Were you ever hospitalized for a reason other than in questions #10, #13 or #16?

What When

15. Tell me about any major injuries you have had (fractures, sprains, injured tendons, etc.)

What When Do you have Permanent Problems/Effects?

16. List any previous (or more recent) work injuries you have had.

What When Do you have Permanent Problems/Effects?

17. List any previous (or more recent) vehicle accidents you have had.

What When Do you have Permanent Problems/Effects?

18. Do you use tobacco? Y N What? \_\_\_\_\_ How many/day? \_\_\_\_\_

Do you use alcohol? Y N DAY \_ WEEK \_ MONTH \_ YEAR \_

**PAIN SYMPTOMS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Pain (Self Report of Severity)**

A. Rate how severe your pain is right now, at this moment (circle a number)

0 1 2 3 4 5 6 7 8 9 10

No pain Most severe pain you can imagine

B. Rate how severe the pain is at its worst (circle a number)

0 1 2 3 4 5 6 7 8 9 10

None Excruciating

C. Rate how severe your pain is on average (circle a number)

0 1 2 3 4 5 6 7 8 9 10

None Excruciating

D. Rate how severe your pain is aggravated by activity (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain Excruciating following any activity

***Sum Score of Section I: A – D = Total pain severity/4 =*** \_\_\_\_\_

E. Rate how frequently you experience pain (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Rarely All the time

***Add total pain severity score***

***(Items A – D/4) to score for item E = \_\_\_\_\_***

***Total pain severity score (range from 0 to 20) = \_\_\_\_\_***

1. **Activity Limitation or Interference**

A. How much does your pain interfere with your ability to walk 1 block? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk Pain makes it impossible for me to walk

B. How much does your pain prevent you from lifting 10 pounds (a bag of groceries)? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent lifting 10 pounds Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to sit for ½ hour? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for ½ hour Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to stand for ½ hour? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to stand for ½ hour Unable to stand for ½ hour

E. How much does your pain interfere with your ability to get enough sleep? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping Impossible to sleep

F. How much does your pain interfere with your ability to participate in social activities? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities Completely interfere with social activities

G. How much does your pain interfere with your ability to travel up to 1 hour by car? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car Completely interfere to travel 1 hour by car.

H. In general, how much does your pain interfere with your daily activities? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities Completely interferes with my daily activities.

I. How much do you limit your activities to prevent your pain from getting worse? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities Completely limits activities

J. How much does your pain interfere with your relationship with your family/partner/significant others? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes with relationships

K. How much does your pain interfere with your ability to do jobs around your home? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely unable to do any job around home

L. How much does your pain interfere with your ability to shower or bathe without help from someone else? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all Completely unable to shower or bathe

M. How much does your pain interfere with your ability to write or type? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to dress yourself? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all My pain makes it impossible to dress

O. How much does your pain interfere with your ability to engage in sexual activities? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all My pain makes it almost impossible to engage in sexual activities

P. How much does your pain interfere with your ability to concentrate? (circle a number)

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 =*** \_\_\_\_\_\_

1. **Individual’s Report of Effect of Pain on Mood**

A. Rate your overall mood during the past week? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good Extremely low/bad

B. During the past week, how anxious or worried have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried Extremely anxious/worried

C. During the past week, how depressed have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed Extremely depressed

D. During the past week, how irritable have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable Extremely irritable

E. In general, how anxious/worried are you about performing activities because they might make your pain/symptoms worse? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried Extremely anxious/worried

***Sum score of Section III:***

***A – E = Total pain impairment attributed to mood state/5 =***

***Mean score = \_\_\_\_\_\_***