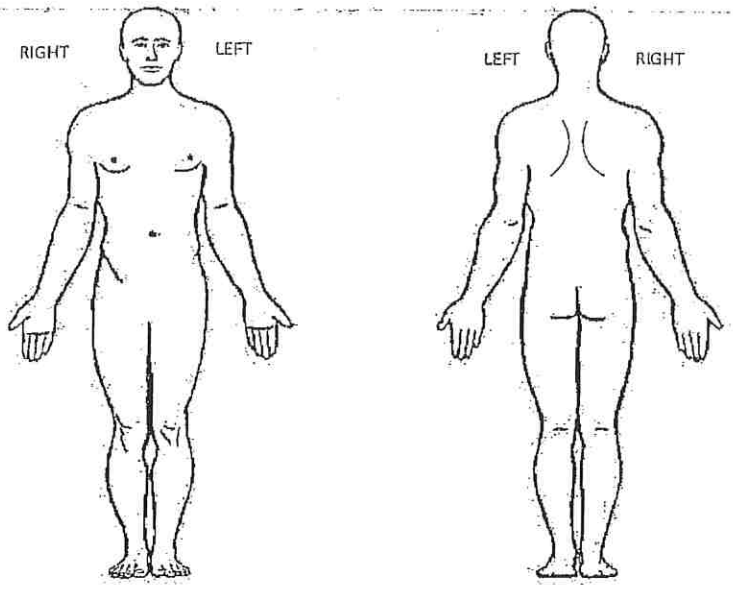
Daily Sheets

Please mark the parts of the body where you have pain



Southern Pain AND Neurological

How do you rate your pain?

Please (circle) your answers:

Describe your pain:
- Aching
- Burning
- Deep, Diffuse
- Discomforting
- Dull
- Electrical
- Localized
- Piercing, Sharp
- Shooting
- Stabbing
- Superficial
- Throbbing

Timing and frequency of your pain:
- Continuous and Constant
- Continuous, but variable intensities
- Intermittent
- Progressive
- Variable
- Daily
- Weekly

Do you have these symptoms:
- Numbness
- Tingling
- Weakness
- Loss of bowel or bladder control
- Pain with coughing or having a BM

Aggravated by:
- Stairs
- Daily activities
- Driving
- Exercise
- 1st steps in the morning
- Leaning back
- Leaning forward
- Movement
- Physical activity
- Sitting
- Standing
- Walking

Relieved by:
- Brace
- Heat
- Ice
- Injections
- Leaning back
- Leaning forward
- Lying Down
- Medications
- Sitting
- Standing
- Stretching
- Walking

Onset of CURRENT episode of pain: _____ weeks, _____months

Have you had physical therapy in the past 3 months? Yes or No PT Facility: _____

Activities of Daily Living : Not affected or Unable to perform (Specify: _____)

Difficulty sleeping? Yes or No (If yes, is it because of pain? Yes or No)

Are you currently working? Yes or No

Patient Name: _____ DOB: _____ Date: _____

1/12/2023

REVIEW OF SYSTEMS

Are you **CURRENTLY** experiencing any of these symptoms

Constitutional
- o No o Yes Fever
- o No o Yes Unexplained weight gain
- o No o Yes Unexplained weight loss
- o Other:_____

Head, Eyes, Ears, Nose & Throat
- o No o Yes Ear drainage
- o No o Yes Nasal drainage
- o No o Yes Sinus pressure
- o No o Yes Sore throat
- o Other:_____

Respiratory
- o No o Yes Chronic cough
- o No o Yes Cough
- o No o Yes Known TB exposure
- o No o Yes Shortness of breath
- o No o Yes Sore throat
- o Other:_____

Cardiovascular
- o No o Yes Chest pain
- o No o Yes Swelling
- o No o Yes Palpitations
- o Other:_____

Gastrointestinal
- o No o Yes Constipation
- o No o Yes Diarrhea
- o No o Yes Nausea
- o No o Yes Vomiting
- o Other:_____

Genitourinary
- o No o Yes Painful urination
- o No o Yes Blood in urine
- o No o Yes Urinary retention
- o Other:_____

Reproductive
- o No o Yes Erectile dysfunction
- o Other:_____

Integumentary
- o No o Yes Brittle hair
- o No o Yes Brittle nails
- o No o Yes Hair loss
- o No o Yes Itching
- o No o Yes Rash
- o Other:_____

Neurological
- o No o Yes Dizziness
- o No o Yes Extremity numbness
- o No o Yes Extremity weakness
- o No o Yes Trouble walking
- o No o Yes Headaches
- o No o Yes Memory loss
- o No o Yes Seizures
- o No o Yes Tremors
- o Other:_____

Psychiatric
- o No o Yes Anxiety
- o No o Yes Depression
- o No o Yes Insomnia
- o Other:_____

Musculoskeletal
- o No o Yes Back pain
- o No o Yes Joint pain
- o No o Yes Joint swelling
- o No o Yes Muscle weakness
- o No o Yes Neck pain
- o Other:_____

Hematologic/Lymphatic
- o No o Yes Easy bleeding
- o No o Yes Easy bruising
- o Other:_____

Patient Name: _____ DOB: _____ Date: _____

OSWESTRY DISABILITY INDEX

This questionnaire is designed to give us information as to how your pain affects your ability to manage in everyday life. Please answer ***every section***. Check ***one box only in each section*** that most closely describes you ***today.***

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 worst imaginable at the moment.

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 is very painful.

☐ 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, 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 if conveniently positioned (i.e. on a table).

☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if conveniently positioned.

☐ I can lift only very light weights.

☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me walking any distance.

☐ Pain prevents me walking more than one mile.

☐ Pain prevents me walking more than a quarter of a mile.

☐ Pain prevents me walking more than 100 yards.

☐ I can only walk using a cane, crutches or walker.

☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

☐ I can sit in any chair as long as I like.

☐ I can sit in my favorite chair as long as I like.

☐ Pain prevents me from sitting more than 1 hour.

☐ Pain prevents me from sitting for more than half an hour.

☐ Pain prevents me from sitting at all.

☐ Pain prevents me from sitting for more than 10 minutes.

Section 6 – Standing

☐ I can stand as long as I want without extra pain.

☐ I can stand as long as I want but it gives me extra pain.

☐ Pain prevents me from standing for more than I hour.

☐ Pain prevents me from standing more than half an hour.

☐ Pain prevents me from standing more than 10 minutes.

☐ Pain prevents me from standing at all.

Section 7 – Sleeping

☐ My sleep is never disturbed by pain.

☐ My sleep is occasionally disturbed by pain.

☐ Because of pain I have less than 6 hours of sleep.

☐ Because of pain I have less than 4 hours of sleep.

☐ Because of pain I have less than 2 hours of sleep.

☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)

☐ My sex life is normal and causes no extra pain.

☐ My sex life is normal but causes some extra pain.

☐ My sex life is nearly normal but is very painful.

☐ My sex life is severely restricted by pain.

☐ My sex life is nearly absent because of pain.

☐ Pain prevents any sex life at all.

Section 9 – Social Life

☐ My social life is normal and causes me no extra pain.

☐ My social life is normal but increases the degree of pain.

☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports, etc.

☐ Pain has restricted my social life and I do not go out as often.

☐ Pain has restricted my social life to home.

☐ I have no social life because of pain.

Section 10 – Traveling

☐ I can travel anywhere without pain.

☐ I can travel anywhere but it gives extra pain.

☐ Pain is bad but I manage journeys over 2 hours

☐ Pain restricts me to journeys of less than 1 hour.

☐ Pain restricts me to short journeys under 30 minutes

☐ Pain prevents me from traveling except to receive treatment.

1/12/2023

Patient name: _____ DOB: _____ Date: _____