Hôpital général juif
Jewish General Hospital
3755, CÔTE STE-CATHERINE, MONTRÉAL, QC H3T 1E2

MRC1098

SPINE QUESTIONNAIRE

Name _____

Date _____

Sex ☐ M ☐ F Age _____

Height _____ Weight _____

Highest level of schooling obtained _____

Smoker: ☐ Yes ☐ No When did you quit? _____

Insurance: ☐ Yes ☐ No **CSST:** ☐ Yes ☐ No

I am working right now ☐ Yes ☐ No Off work since _____

Occupation _____

Type of work: ☐ Homemaker ☐ Light labour ☐ Heavy labour ☐ Sedentary work ☐ Medium labour

GENERALLY:

- ☐ I am not handicapped by my spine problem
- ☐ I have pain but only mild disability and can do my usual duties
- ☐ I have pain and can only do light duties
- ☐ I cannot work but I am able to walk outside
- ☐ I cannot work and I have difficulty walking even short distances
- ☐ I am not working right now because of my back problem
- ☐ I have had unexplained weight loss
- ☐ My pain is worse at night
- ☐ I have unexplained fever and night sweats

PREVIOUS LUMBAR SURGERIES: ☐ Yes ☐ No

If so, which ones?

_____

_____

_____

_____

_____

I HAVE HAD THE FOLLOWING TREATMENTS

- ☐ Physiotherapy ____ weeks
- ☐ Medication ____ weeks
- ☐ Other _____
- ☐ No treatment

IMPROVEMENT SINCE THE BEGINNING OF THE PAIN

- ☐ Worse
- ☐ Not at all better (0 %)
- ☐ A little better (5-30 %)
- ☐ Significantly better (35 65 %)
- ☐ Much better (+ 70 %)

I HAVE THIS PROBLEM SINCE

____ Weeks

____ Months

____ Years

Instructions: This questionnaire has been designed to give us information as to how your back or leg pain has affected your ability to manage in everyday life. **Please answer every section.** We realize you may consider that two of the statements in any section relates to you. MARK ONLY THE **ONE** BOX which applies to you.

1 – PAIN INTENSITY *(check only one)*

- ☐ I have no pain at this 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 worst imaginable at the moment

2 – PERSONAL CARE *(check only one)*

- ☐ I can look after myself without causing extra pain
- ☐ I can look after myself but it's very painful
- ☐ It's painful to look after myself I'm slow and careful
- ☐ I need some help but I manage most of my personal care
- ☐ I don't get dressed, wash with difficulty, stay in bed

3 – LIFTING *(check only one)*

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are positioned
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if positioned.
- ☐ I cannot lift or carry anything at all

4 – WALKING *(check only one)*

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ¼ mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5 – SITTING *(check only one)*

- ☐ I can sit in any chair as long as I like
- ☐ I can sit in my favourite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6 – STANDING *(check only one)*

- ☐ 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 more than 1 hour
- ☐ Pain prevents me from standing more than ½ hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

7 – SLEEPING *(check only one)*

- ☐ My sleep in never disturbed by pain
- ☐ My sleep is occasionnaly disturbed by pain
- ☐ Because of my pain, I have less than 6 hours of sleep
- ☐ Because of my pain, I have less than 4 hours of sleep
- ☐ Because of my pain, I have less than 2 hours of sleep
- ☐ Pain prevents me from sleeping at all

8 – SEX LIFE *(check only one)*

- ☐ 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 severly restricted by pain
- ☐ My sex life is nearly absent because of the pain
- ☐ Pain prevents any sex life at all

9 – SOCIAL LIFE *(check only one)*

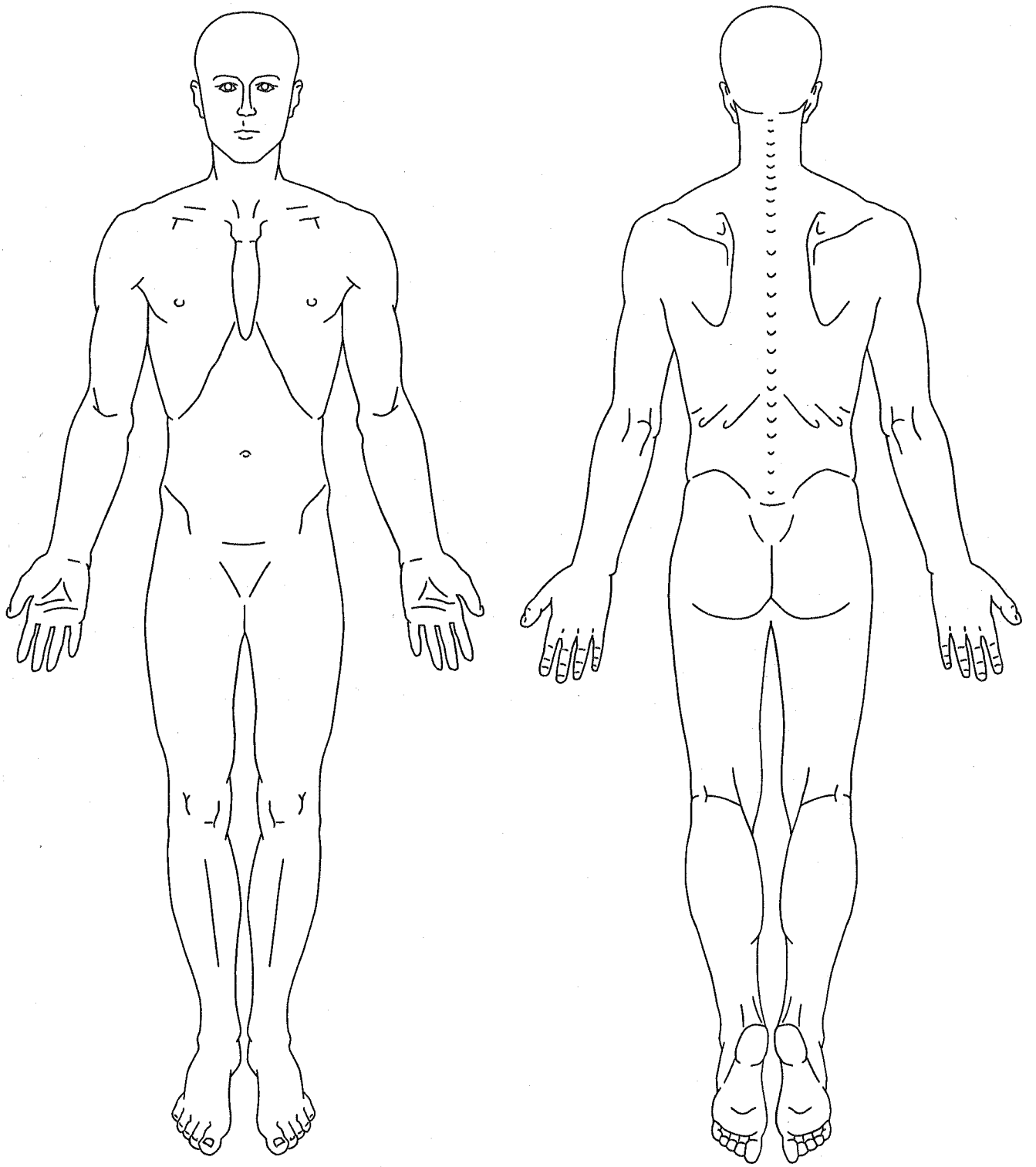
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my life apart from limiting my more energetic interests
- ☐ Pain restricts my social life and I do not get out as often
- ☐ Pain has restricted my social life to home
- ☐ I have no social life because of pain

10 – TRAVELING *(check only one)*

- ☐ I can travel anywhere without extra 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 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Please mark on the drawings the areas of your body where you feel your pain.
Use only the appropriate symbols of pain that you will find below.
Include all of the affected areas.

Numbness	Pins & Needles	Burning	Stabbing or sharp	Ache or dull
= = =	* * *	x x x	/ / /	v v v v



Please answer the following questions
(your responses will be kept confidential)

1. Is someone else primarily to blame for your situation?	☐ Yes	☐ No
2. Are you having trouble at work; home; with friends (due to this injury)?	☐ Yes	☐ No
3. Are you receiving or anticipate receiving any financial compensation for your injury?	☐ Yes	☐ No
4. Have you contacted a lawyer about your injury?	☐ Yes	☐ No
5. Are you having trouble sleeping because of your pain?	☐ Yes	☐ No
6. Is the pain constant, never goes away?	☐ Yes	☐ No
7. Has medication and/or previous treatment helped?	☐ Yes	☐ No
8. Have you had more than 2 medical consultations for this injury?	☐ Yes	☐ No
9. Is it essential that you find out the physical source of your symptoms?	☐ Yes	☐ No
10. Has your pain spread to other parts of your body beyond your spine?	☐ Yes	☐ No

Patient's signature _____ Date _____

Thank You
for your time completing this form.