CARE CONNECTIONS

LUMBAR

NAME _____ DATE _____

TIME _____ AM/PM ❒ Initial Visit ❒ Discharge Visit

FUNCTIONAL INDEX

Choose the one answer in each section that best describes your condition.

WALKING

❒ Symptoms do not prevent me walking any distance.
❒ Symptoms prevent me walking more than 1 mile.
❒ Symptoms prevent me walking more than 1/2 mile.
❒ Symptoms prevent me walking more than 1/4 mile.
❒ I can only walk using a stick or crutches.
❒ I am in bed most of the time and have to crawl to the toilet.

WORK

(Applies to work in home and outside)

❒ 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.
❒ I can hardly do any work at all (only light duty).
❒ I cannot do any work at all.

PERSONAL CARE

(Washing, Dressing, etc.)

❒ I can manage all personal care without symptoms.
❒ I can manage all personal care with some increased symptoms.
❒ Personal care requires slow, concise movements due to increased symptoms.
❒ I need help to manage some personal care.
❒ I need help to manage all personal care.
❒ I cannot manage any personal care.

SLEEPING

❒ I have no trouble sleeping.
❒ My sleep is mildly 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).

RECREATION/SPORTS

(Indicate Sport if Appropriate _____)

❒ I am able to engage in all my recreational/sports activities without increased symptoms.
❒ I am able to engage in all my recreational/sports activities with some increased symptoms.
❒ I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
❒ I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
❒ I can hardly do any recreational/sports activities because of increased symptoms.
❒ I cannot do any recreational/sports activities at all.

DRIVING

❒ I can drive my car or travel without any extra symptoms.
❒ I can drive my car or travel as long as I want with slight symptoms.
❒ I can drive my car or travel as long as I want with moderate symptoms.
❒ I cannot drive my car or travel as long as I want because of moderate symptoms.
❒ I can hardly drive at all or travel because of severe symptoms.
❒ I cannot drive my car or travel at all.

LIFTING

❒ I can lift heavy weights without extra symptoms.
❒ I can lift heavy weights, but it gives extra symptoms.
❒ My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
❒ My symptoms prevent me from lifting heavy weights, but I 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.

STANDING

❒ I can stand as long as I want without increased symptoms.
❒ I can stand as long as I want, but it gives me extra symptoms.
❒ Symptoms prevent me from standing for more than 1 hour.
❒ Symptoms prevent me from standing for more than 30 minutes.
❒ Symptoms prevent me from standing for more than 10 minutes.
❒ Symptoms prevent me from standing at all.

SQUATTING

❒ I can squat fully without the use of my arms for support.
❒ I can squat fully, but with symptoms or using my arms for support.
❒ I can squat 3/4 of my normal depth, but less than fully.
❒ I can squat 1/2 of my normal depth, but less than 3/4.
❒ I can squat 1/4 of my normal depth, but less than 1/2.
❒ I am unable to squat any distance due to symptoms .

SITTING

❒ I can sit in any chair as long as I like.
❒ I can only sit in my favorite chair as long as I like.
❒ My symptoms prevent me sitting more than 1 hour.
❒ My symptoms prevent me sitting more than 1/2 hour.
❒ My symptoms prevent me sitting more than 10 minutes.
❒ My symptoms prevent me from sitting at all.

** Lumbar questions adapted from Oswestry.*

ACUITY *(Answer on initial visit.)*

How many days ago did onset/injury occur? _____ days

Please complete opposite side

PAIN INDEX

Please indicate the worst your pain has been in the last 24 hours on the scale below

No Pain ——————————————— Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

GLOBAL RATING OF CHANGE

With respect to the reason you sought treatment, how would you describe yourself now compared to your first treatment at our clinic? (Circle one)

■ WORK STATUS *(check most appropriate)*

1. ❒ No lost work time
2. ❒ Return to work without restriction
3. ❒ Return to work with modification
4. ❒ Have not returned to work
5. ❒ Not employed outside the home

Work days lost due to condition:_____ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: _____