SRS-22r Patient Questionnaire

Patient Name: ____________ ________ ______________ Date of Birth:____ _____ ____
First MI Last Mo Day Yr

Today's Date: ____ ______ ________ Age: _____+_______
Mo Day Yr Yrs Mo

Medical Record #: ___________________

INSTRUCTIONS: We are carefully evaluating the condition of your back and it is **IMPORTANT THAT YOU ANSWER EACH OF THESE QUESTIONS YOURSELF.** Please **CIRCLE THE ONE BEST ANSWER TO EACH QUESTION.**

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?

   None
   Mild
   Moderate
   Moderate to severe
   Severe

2. Which one of the following best describes the amount of pain you have experienced over the last month?

   None
   Mild
   Moderate
   Moderate to severe
   Severe

3. During the past 6 months have you been a very nervous person?

   None of the time
   A little of the time
   Some of the time
   Most of the time
   All of the time

(CONTINUED ON NEXT PAGE)

4. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?

   Very happy
   Somewhat happy
   Neither happy nor unhappy
   Somewhat unhappy
   Very unhappy

5. What is your current level of activity?

   Bedridden
   Primarily no activity
   Light labor and light sports
   Moderate labor and moderate sports
   Full activities without restriction

6. How do you look in clothes?

   Very good
   Good
   Fair
   Bad
   Very bad

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?

   Very often
   Often
   Sometimes
   Rarely
   Never

8. Do you experience back pain when at rest?

   Very often
   Often
   Sometimes
   Rarely
   Never

9. What is your current level of work/school activity?

   100% normal
   75% normal
   50% normal
   25% normal
   0% normal

(CONTINUED ON NEXT PAGE)

10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?

Very good
Good
Fair
Poor
Very Poor

11. Which one of the following best describes your pain medication use for back pain?

None
Non-narcotics weekly or less (e.g., aspirin, Tylenol, Ibuprofen)
Non-narcotics daily
Narcotics weekly or less (e.g. Tylenol III, Lorcet, Percocet)
Narcotics daily

12. Does your back limit your ability to do things around the house?

Never
Rarely
Sometimes
Often
Very Often

13. Have you felt calm and peaceful during the past 6 months?

All of the time
Most of the time
Some of the time
A little of the time
None of the time

14. Do you feel that your back condition affects your personal relationships?

None
Slightly
Mildly
Moderately
Severely

(CONTINUED ON NEXT PAGE)

15. Are you and/or your family experiencing financial difficulties because of your back?

    Severely
    Moderately
    Mildly
    Slightly
    None

16. In the past 6 months have you felt down hearted and blue?

    Never
    Rarely
    Sometimes
    Often
    Very often

17. In the last 3 months have you taken any days off of work, including household work, or school because of back pain?

    0 days
    1 day
    2 days
    3 days
    4 or more days

18. Does your back condition limit your going out with friends/family?

    Never
    Rarely
    Sometimes
    Often
    Very often

19. Do you feel attractive with your current back condition?

    Yes, very
    Yes, somewhat
    Neither attractive nor unattractive
    No, not very much
    No, not at all

20. Have you been a happy person during the past 6 months?

    None of the time
    A little of the time
    Some of the time
    Most of the time
    All of the time

(CONTINUED ON NEXT PAGE)

21. Are you satisfied with the results of your back management?

Very satisfied
Satisfied
Neither satisfied nor unsatisfied
Unsatisfied
Very unsatisfied

22. Would you have the same management again if you had the same condition?

Definitely yes
Probably yes
Not sure
Probably not
Definitely not

Thank you for completing this questionnaire. Please comment if you wish.

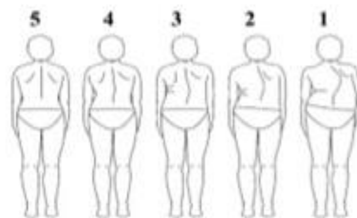
3-10-06

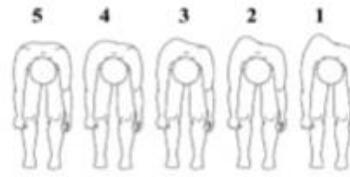
END

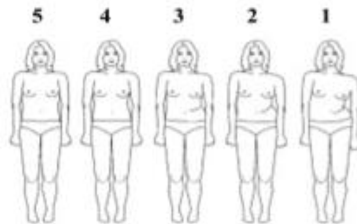
TRUNK APPEARANCE PERCEPTION SCALE- (TAPS)

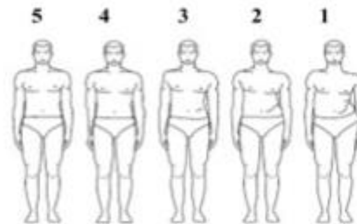
Maximum best score achieved if patient circles the number 5 in all three sets: 15/3 = 5 points.

Maximum worse score achieved if patient circles the number 1 in all three sets: 3/3 = 1 point.









hez-Raya J, Pérez-Grueso FJ Sánchez, Climent JM: The Trink Appearance Perception Scale (TAPS):
› evaluate subjective impression of trunk deformity in patients with idiopathic scoliosis.
.0, 5:6.

ADVANCED CARE PHYSICAL THERAPY
PATIENT HISTORY FORM

Patient's Name: ________________________ Date of Birth: ___________________
Height:________________________________ Weight:________________

General Health
Do you smoke? Yes No **Do you drink? Yes No** **Do you have a pacemaker? Yes No**

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: ____

Have you RECENTLY noted any of the following (check all that apply)?
- o Fatigue
- o Fever/chills/sweats
- o Difficulty maintaining balance and/or falls
- o Unexplained weight loss/gain
- o Nausea/vomiting
- o Changes in bowel/bladder habits

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- o Cancer
- o Heart problems/Disease
- o Chest pain/angina
- o High blood pressure
- o Circulation problems
- o Blood clots
- o Stroke
- o Anemia/blood problems
- o Bone or joint infection
- o Chemical dependency
- o High cholesterol
- o Diabetes
- o Stroke
- o Anxiety
- o Headache/migraine
- o Low blood pressure
- o Depression
- o Lung problems/cough
- o Arthritis
- o Bladder/urinary tract infection
- o Kidney problem/infection
- o Sexually transmitted disease/HIV
- o Thyroid problems
- o Osteoporosis
- o Multiple sclerosis
- o Epilepsy / Seizures
- o Eye problem/infection
- o Ulcers / Colitis
- o Liver problems/ Hepatitis
- o Asthma
- o Other:

Are you experiencing any of the following (check all that apply)?
- o Numbness or tingling
- o Muscle weakness
- o Dizziness/lightheadedness
- o Double Vision
- o Heartburn/indigestion
- o Difficulty swallowing or speaking
- o Changes in bowel or bladder function
- o Headaches

Please list any medications you are currently taking.

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

<u>History of Present Illness</u>

What date (roughly) did your present problem start? ________________________________

My symptoms are currently: Getting Better, Getting Worse, Staying about the same

Treatment received so far for this problem (chiropractic, injections, surgery, etc):

____

Please list special tests performed for this problem (x-ray, MRI, EMG etc)

____

General Health:

At the present time, would you say that your health is excellent, very good, fair, or poor?

Excellent Very good Fair Poor

____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature: _____________________________________ Date: ___________