Name _____ Date_____ ____Initial Eval. ____ Follow up Eval.

This questionnaire should be filled out by any patient with chronic pain. It will only take a few minutes to fill out. THANK YOU FOR PAYING ATTENTION TO ALL DETAILS IN FILLING. Having this information prepared will help us spend our time together more efficiently.

_____

1. In the last week, how far are you usually able to **walk before you feel that you <u>strongly want to stop</u> due to discomfort?**

_____ Less than 100 feet _____ Over 100 but less than 250 Ft (1/2 block)
_____ Over 250 but less than 500 feet (1 block) _____ Over 1 block but less than 2 blocks
_____ Over 2 blocks but less than 5 blocks _____ Over 5 blocks but less than 1 mile
_____ Over 1 mile but less than 2 miles _____ Over 2 miles but less than 3 miles
_____ Over 3 miles but I still need to stop at times because of discomfort
_____ I do not need to stop because of discomfort _____ I do not walk enough to test myself

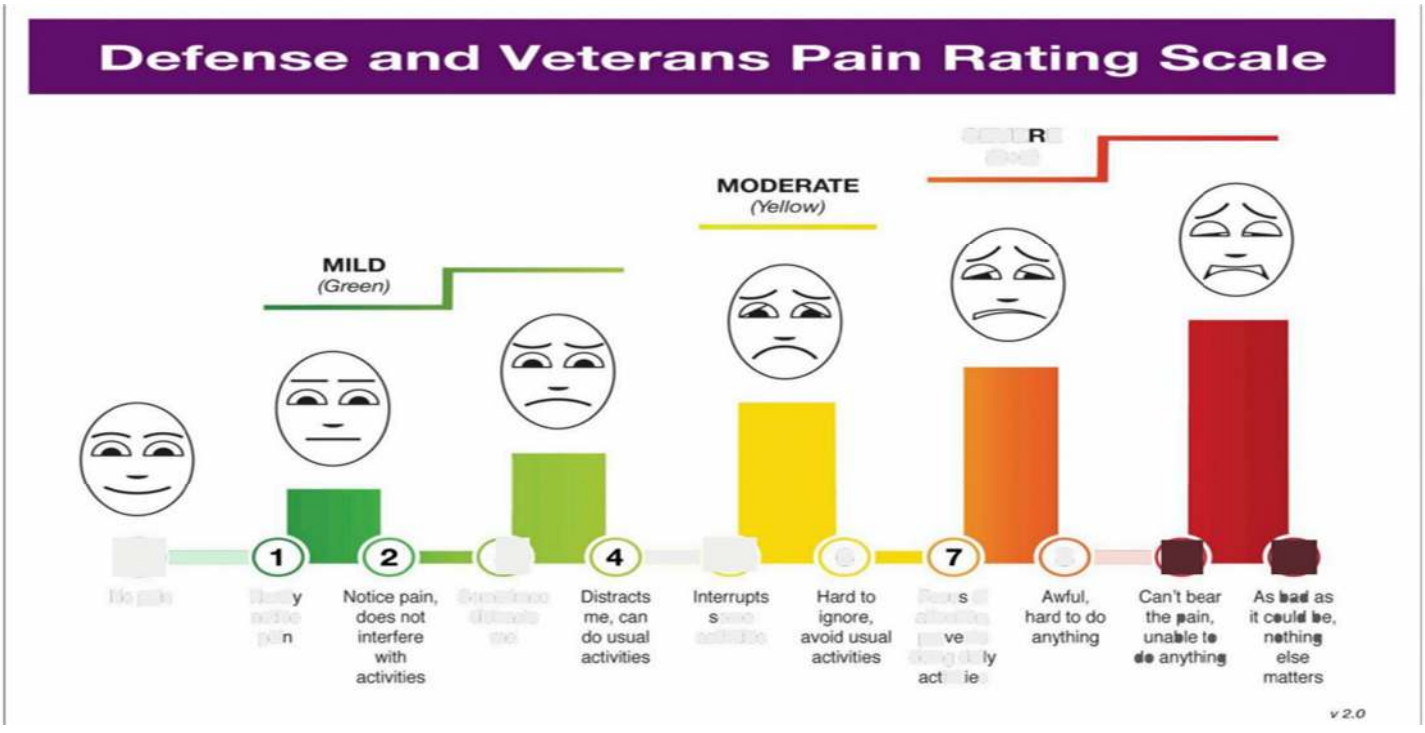
2. **In the last week, how long can you usually stand before you <u>strongly want to sit</u> (or change positions)** because of discomfort?

_____ Less than 2 minutes _____ More than 2 minutes but less than 5 minutes
_____ More than 5 but less than 10 minutes _____ More than 10 but less than 20 minutes
_____ Over 20 but less than 30 minutes _____ Over 30 minutes but I still sometimes need to sit
_____ I do not need to sit or switch positions _____ I do not stand long enough to test myeself

3. **In the last week, how long can you usually SIT (including in a car) before you <u>strongly want to stand up</u> or <u>change sitting position</u>** because of discomfort?

_____ Less than 10 minutes _____ More than 10 but less than 30 minutes
_____ More than 30 minutes but less than 1 hour _____ More than 1 hour but less than 3 hours
_____ Over 3 hours, but I still sometimes need to change positions or stand to get relief.
_____ Over 3 hours, and I standardly do not need to change positions or stand for any relief.

For the Remaining Questions, please be guided by the DOD Pain Scale



Do you have a diagnosis and current symptoms (or current treatment) of any of the following conditions?

If so fill out the box for each category, which identifies concerns of the past week only.

4. Peripheral Artery Disease (poor circulation) causing leg pain with walking

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Have you had your circulation tested? ___ N0 ___ Yes Most Recent ABI _____

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

5. Pain or discomfort from swelling in leg or legs.

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

What is the cause of the swelling? _____Unknown _____ Blood Clot _____ Vein Problem

_____ Circulation _____Lymphedema _____ Lipedema _____ Arthritis _____ Injury or Surgery

_____ Heart Problem ____ Lung Problem _____ Kidney Problem Other _____

If you have had compression therapy (stockings, wraps, or a compression pump) were you able to

_____ Tolerate it comfortably _____ Tolerate it with some discomfort

_____ Tolerate with significant discomfort _____ Often not tolerate it _____ Usually not tolerate it.

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

6. Restless Leg Syndrome

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

7. Leg Cramps or other leg symptoms (other than Sciatica) at night in bed

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

8. Poor Balance

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

9. Difficulty bending over to pick something up from the floor

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

10. Shortness of breath with walking (exertional dyspnea)

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

What is the cause? _____ Heart Problem _____ Lung problem Other _____

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

11. **Neck Pain**

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

12. Depression

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

13. Peripheral Neuropathy **Diagnosed Cause: _____**

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

14. Please identify the common or usual level of foot symptoms of Neuropathy in the last week.

	None	**Mild**	**Moderate**	**Severe**
Numbness	0	1 2 3	4 5 6 7	8 9 10
Paresthesias (Pins and needles)	0	1 2 3	4 5 6 7	8 9 10
Burning	0	1 2 3	4 5 6 7	8 9 10
Pain	0	1 2 3	4 5 6 7	8 9 10
Aching	0	1 2 3	4 5 6 7	8 9 10
Cold feeling	0	1 2 3	4 5 6 7	8 9 10
Stiff Feeling (Leather / Cardboard)	0	1 2 3	4 5 6 7	8 9 10

15. Arthritis of the either the _____ Left Hip or _____ Right Hip

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

16. Arthritis of the either the _____ Left Knee or _____ Right Knee

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

17. Arthritis of either the _____ Left foot or ankle or the _____ Right foot or ankle

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

18. **Fibromyalgia**

No _____ Yes _____ For Up to 6 months 6-12 months Over 1 year

Please rate this concern by circling the number that best describes how you have experienced it at it's **A V E R A G E in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

Please rate this concern by circling the number that best describes how you have experienced it at it's **W O R S T in the last 7 DAYS (1 week).**

0 1 2 3 4 5 6 7 8 9 **10**

No Problem **Severe symptoms or effect**

THANK YOU FOR DOING YOUR BEST TO PREPARE THIS INFORMATION FOR YOUR VISIT!