

SPINE AND SPORT BIOMECHANICAL REHABILITATION CENTER

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Name: _____ Date: _____

PART A: Medicare Lower Extremity Functional Scale

Today, do you or would you have any difficulty with (please circle **only one** number that corresponds with your level of function):

0 = Extreme difficulty / unable to perform at all 1 = Quite a bit of difficulty 2 = Moderate difficulty 3 = A little bit of difficulty 4 = No difficulty

YOU MUST ANSWER EVERY QUESTION.

1.	<u>Any of your usual work, housework, or school activities</u>	0	1	2	3	4
2.	<u>Your usual hobbies, recreational, or sporting activities</u>	0	1	2	3	4
3.	<u>Getting into or out of the bath</u>	0	1	2	3	4
4.	<u>Walking between rooms</u>	0	1	2	3	4
5.	<u>Putting on your shoes or socks</u>	0	1	2	3	4
6.	<u>Squatting</u>	0	1	2	3	4
7.	<u>Lifting an object, like a bag of groceries from the floor</u>	0	1	2	3	4
8.	<u>Performing light activities around the house</u>	0	1	2	3	4
9.	<u>Performing heavy activities around the house</u>	0	1	2	3	4
10.	<u>Getting into or out of a car</u>	0	1	2	3	4
11.	<u>Walking two blocks</u>	0	1	2	3	4
12.	<u>Walking a mile</u>	0	1	2	3	4
13.	<u>Going up or down ten stairs (about one flight)</u>	0	1	2	3	4
14.	<u>Standing for one hour</u>	0	1	2	3	4
15.	<u>Sitting for one hour</u>	0	1	2	3	4
16.	<u>Running on even ground</u>	0	1	2	3	4
17.	<u>Running on uneven ground</u>	0	1	2	3	4
18.	<u>Making sharp turns while running fast</u>	0	1	2	3	4
19.	<u>Hopping</u>	0	1	2	3	4
20.	<u>Rolling over in bed</u>	0	1	2	3	4

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

PART B: Body Diagram

Please indicate where your pain is located and what type of pain you feel at the *present* time. Fill in the area on the body diagram with the appropriate symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition

Key:

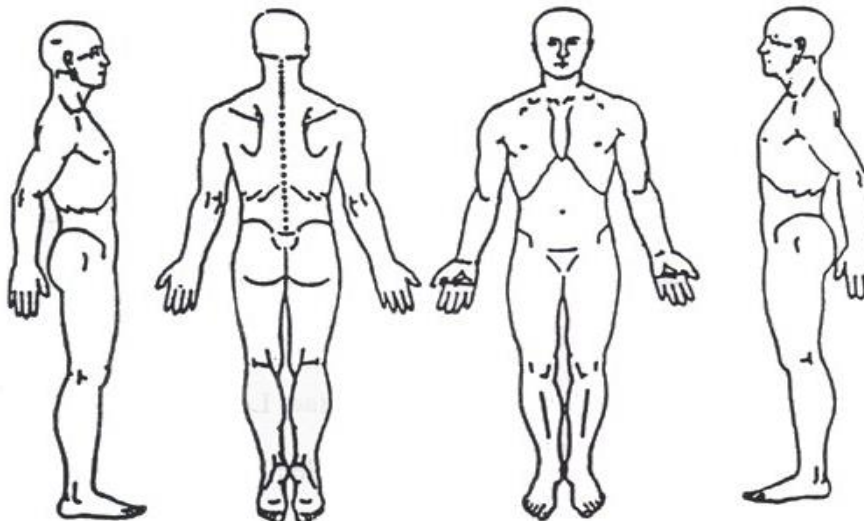
Stabbing: ///

Burning: XXX

Pins and Needles: 000

Numbness: ===

Other: (●●●) _____



PART C: Medicare Low Back Disability Questionnaire

Please answer every section and circle a number in each section only **ONCE** which applies to you. We realize you may consider that two statements in any one section relate to you, but please **ONLY CIRCLE** the number which **MOST CLOSELY** describes your problem.

YOU MUST ANSWER EVERY QUESTION.

Section 1: Pain Intensity

0. I can tolerate the pain without having to use painkillers
1. The pain is bad but I can manage without painkillers
2. Painkillers give complete relief from my pain
3. Painkillers give moderate relief from my pain
4. Painkillers give very little relief from my pain
5. Painkillers have no effect on the pain; I do not use them

Section 2: Personal Care (Washing, Dressing etc.)

0. I can look after myself without causing extra pain
1. I can look after myself normally but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self care
5. I do not get dressed, wash with difficulty, and stay in bed

Section 3: Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
3. Pain prevents me from lifting heavy weights but I can manage light / medium weights if conveniently positioned
4. I can lift only light weights
5. I cannot lift or carry anything at all

Section 4: Walking

0. Pain does not prevent me from walking any distance
1. Pain prevents me from walking more than one mile
2. Pain prevents me from walking more than one-half mile
3. Pain prevents me from walking more than a quarter mile
4. I can only walk using a stick or crutches
5. I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting

0. I can sit in any chair as long as I like
1. I can sit in my favorite chair as long as I like
2. Pain prevents me from sitting more than one hour
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting almost all of the time

Section 6: Standing

0. I can stand as long as I want to without extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing more than 1 hour
3. Pain prevents me from standing more than 30 minutes
4. Pain prevents me from standing more than 10 minutes
5. Pain prevents me from standing at all

Section 7: Sleeping

0. I have no trouble sleeping
1. I can sleep well only by using tablets
2. Even when I take tablets I have less than 6 hours of sleep
3. Even when I take tablets I have less than 4 hours of sleep
4. Even when I take tablets I have less than 2 hours of sleep
5. Pain prevents me from sleeping at all

Section 8: Social Life

0. My social life is normal and gives me no extra pain
1. My social life is normal but increases the degree of pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests (ex. dancing)
3. Pain has restricted my social life and I do not go out often
4. Pain has restricted my social life to my home
5. I have no social life because of my pain

Section 9: Traveling

0. I can travel anywhere without extra pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over 2 hours
3. Pain is bad but I manage journeys less than 1 hour
4. Pain restricts me to short necessary journeys under 30 min.
5. Pain prevents me from traveling except to appointments

Section 10: Changing Degree of Pain

0. My pain is rapidly getting better
1. My pain fluctuates but overall is definitely getting better
2. My pain seems to be getting better but improvement is slow at the present time
3. My pain is neither getting better nor worse
4. My pain is gradually worsening
5. My pain is rapidly worsening

Please answer *every question*, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

PART D: Visual Analogue Scale

Make a slash (/) along the line from the extremes, which you think represents your current pain in your major area of injury

No Pain at All

Pain as Bad As It Could Be



