



Draft

BACK AND LEG PAIN QUESTIONNAIRE

(Information to be obtained from the patient)

Protocol Number:

P 0 1 - **0 5**

Patient IDE No.:

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Patient Initials:

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Exam Date (mm/dd/yyyy):

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MARK ONE:

Preop

6 wks. postop

3 mo. postop

6 mo. postop

12 mos. postop

24 mos. postop

36 mo. postop

48 mo. postop

INSTRUCTIONS: This form is for the purpose of collecting back pain and leg pain information from you. Answer **every** question by filling in the appropriate circle. If you need to change an answer, draw a line through your original answer and then fill in the correct circle. Please place your initials and date by any change you make. If you are unsure about how to answer a question, please give the best answer you can. Mark only one answer for each question.

Shade Circles Like This--> ●

Not Like This--> ~~○~~ ○

BACK PAIN

1. On the scale of 0 to 10, mark your intensity of **back** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain As Bad As It Could Be
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

2. On the scale of 0 to 10, mark how often you had **back** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	All Of The Time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

LEG PAIN

3. On the scale of 0 to 10, mark your intensity of **leg** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain As Bad As It Could Be
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

4. On the scale of 0 to 10, mark how often you had **leg** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	All Of The Time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Initials of Person Completing Form:

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