CARE CONNECTIONS

**LUMBAR**

NAME

DATE ❒ 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

## IMPROVEMENT INDEX

*Please indicate the amount of improvement you have made since the beginning of your treatment on the scale below.*

No Improvement ——————————————— Complete Recovery

## ■ 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: _____*