

# ORTHOPAEDIC RE-EVALUATION QUESTIONNAIRE (JCC)

Please accept our apologies for the overly lengthy and detailed form you are about to complete. Completion of this questionnaire will allow for the most complete and quickest compilation of your report.

PLEASE PRINT:

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

CIRCLE ONE:                      Right-handed                      Left-handed

1. How long have you been off work, or were you off work, due to this injury, since I last evaluated you?

\_\_\_\_\_

2. a. Who did you see for medical care following my last examination?

\_\_\_\_\_

b. What type of doctor was he or she?

\_\_\_\_\_

c. When did you first see that doctor?

\_\_\_\_\_

3. a. What other doctors or health care practitioners have you seen in relation to your injury since I last evaluated you?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b. Who is your family doctor? \_\_\_\_\_

c. Who is your current treating doctor for your work injury? \_\_\_\_\_

\_\_\_\_\_

4. Check the type of tests you have undergone since my last evaluation:

**Check all tests you have had:**

<input type="checkbox"/>	EEG	<input type="checkbox"/>	Myelogram	<input type="checkbox"/>	Nerve Tests (EMG/NCV)
<input type="checkbox"/>	ENG	<input type="checkbox"/>	Spinal Tap	<input type="checkbox"/>	Urine Test
<input type="checkbox"/>	Hearing Tests	<input type="checkbox"/>	Blood Tests	<input type="checkbox"/>	Psychological Testing
<input type="checkbox"/>	X-rays of:	<input type="checkbox"/>	MRI of:	<input type="checkbox"/>	CT scan of:

Other tests: \_\_\_\_\_

5. Were you ever denied medical treatment? ( ) Yes ( ) No

If yes, explain why treatment was denied: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**CURRENT COMPLAINTS**

6. Do you have any continuing pain or discomfort currently as a result of the injury you are being evaluated for? \_\_\_\_\_

7. If yes, complete the table and diagram below:

	Affected body parts. Please list the most troublesome to the least troublesome.	Type of pain (i.e., aching, a dull deep pain; sharp: a sudden, intense knife-life pain; burning; radiating; a pain that travels.	What activities or treatment make the pain better?	What activities or treatment make the pain worse?
MOST PAINFUL				
LEAST PAINFUL				

8. Using the following key, describe your present ailment on the diagram below:

KEY

Major Pain: XXX	Tingling: YYY
Secondary Pain: III	Burning: ZZZ
Loss of Sensation: 000	

9. a. Can you drive? \_\_\_\_\_  
 b. Can you shop? \_\_\_\_\_  
 c. Can you do housework? \_\_\_\_\_

10. Are there any sports/hobbies/activities that you can no longer do because of your work injury? Are there work activities you can no longer do? ( ) YES ( ) NO

If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The heaviest object I can lift weighs \_\_\_\_\_ pounds.

I am able to walk \_\_\_\_\_ (distance).

I am able to sit for \_\_\_\_\_ (minutes/hours) before I must stand.

I am able to stand for \_\_\_\_\_ (minutes/hours) before I must rest.

Prior to this injury:

I could regularly lift up to \_\_\_\_\_ pounds.

I was able to walk \_\_\_\_\_ (distance).

I was able to sit for \_\_\_\_\_ (minutes/hours).

I was able to stand for \_\_\_\_\_ (minutes/hours).

11. Have you had surgeries of any type? ( ) YES ( ) NO If YES, please indicate what type(s):

TYPE OF SURGERY	MONTH/YEAR	HOSPITAL	DOCTOR
a. _____			
b. _____			
c. _____			
d. _____			

12. Have you had any non-surgical hospitalizations? ( ) YES ( ) NO

If YES, indicate what type(s). *FEMALE PATIENTS: Please include childbirth(s).*

	TYPE OF HOSPITALIZATION	MONTH/YEAR	HOSPITAL	DOCTOR
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____

13. Are you presently taking any medications? ( ) YES ( ) NO

If YES, please list them **ALL**:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Do you have any ALLERGIES to medications? ( ) YES ( ) NO

If YES, to what? \_\_\_\_\_

15. Did you work for any other employer at the SAME TIME that you were working at the job where you were injured? \_\_\_\_\_

( ) YES ( ) NO

16. If YES, then respond to the following:

- a. Name of employer \_\_\_\_\_
- b. Location of employer \_\_\_\_\_
- c. Occupation/Work Duties \_\_\_\_\_
- d. From when \_\_\_\_\_ to when \_\_\_\_\_
- e. Hours per week \_\_\_\_\_

17. Have you worked anywhere **FOLLOWING** working for the employer where you were injured?

( ) YES ( ) NO

18. If YES, respond to the following:

a. Are you **CURRENTLY** employed? ( ) YES ( ) NO

b. If currently employed, by whom? \_\_\_\_\_

c. Where is the employer located? \_\_\_\_\_

d. What is your occupation there? \_\_\_\_\_

e. When did you begin work there? \_\_\_\_\_

If there are additional employers after the work injury, please fill in #19-21.

19. a. Name of later employer \_\_\_\_\_

b. Location of employer \_\_\_\_\_

c. Occupation/Work Duties \_\_\_\_\_

d. Period of Employment **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

20. a. Name of later employer \_\_\_\_\_

b. Location of employer \_\_\_\_\_

c. Occupation/Work Duties \_\_\_\_\_

d. Period of Employment **FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

21. If you had a **THIRD OR ANY ADDITIONAL** later employment, please use the back of this page and answer the same questions as #19 and #20.

You're finished? Thanks again for your patience.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**I. Pain (Self-report of Severity)**A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 No pain Most severe pain can imagine

B. Rate how severe your pain is at **its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 None Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Activity does not Excruciating following  
 aggravate pain any activity

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Rarely All of the time

Total pain severity score (range from 0 to 20) = \_\_\_\_\_

**II. Activity Limitation or Interference**A. How much does your pain interfere with your ability to **walk 1 block?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict Pain makes it impossible  
 ability to walk for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent from Impossible to lift  
 lifting 10 pounds 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not restrict ability Impossible to sit  
 to sit for 1/2 hour for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Pain does not interfere Unable to  
 with ability to stand at all stand at all

E. How much does your pain interfere with your ability to **get enough sleep?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not prevent me Impossible  
 from sleeping to sleep

F. How much does your pain interfere with your ability to **participate in social activities?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely interferes  
 with social activities with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere with ability Completely unable to  
 to travel 1 hour by car travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely interferes  
 with my daily activities with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not limit Completely limits  
 activities activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely interferes  
 with relationships with relationships

K. How much does your pain interfere with your ability to **do jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere Completely unable to  
 do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
 Does not interfere My pain makes it impossible to  
 at all shower or bathe without help

M. How much does your pain interfere with your ability to write or type? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere at all My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to dress yourself? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere at all My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to engage in sexual activities? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Does not interfere at all My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to concentrate? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Never All the time

/  
K \_\_\_\_\_ =

III. Individual's Report of Effect of Pain on Mood

A. Rate your overall mood during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Extremely high/good Extremely low/bad

B. During the past week, how anxious or worried have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Not at all anxious/worried Extremely anxious/worried

C. During the past week, how depressed have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Not at all depressed Extremely depressed

D. During the past week, how irritable have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10  
Not at all irritable Extremely irritable

E. In general, how anxious/worried are you about performing activities because they might make your pain/symptoms worse?

0 1 2 3 4 5 6 7 8 9 10  
Not at all anxious/worried Extremely anxious/worried

S  
/ \_\_\_\_\_ =



# Epworth Sleepiness Scale

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Your age: (Yr) \_\_\_\_\_ Your sex:  Male  Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

- 0 = would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation

Chance of dozing

Sitting and reading .....	<input type="text"/>
Watching TV .....	<input type="text"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting) .....	<input type="text"/>
As a passenger in a car for an hour without a break .....	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit .....	<input type="text"/>
Sitting and talking to someone .....	<input type="text"/>
Sitting quietly after a lunch without alcohol .....	<input type="text"/>
In a car, while stopped for a few minutes in the traffic .....	<input type="text"/>
Total .....	<input type="text"/>

Score:
0-10 Normal range
10-12 Borderline
12-24 Abnormal