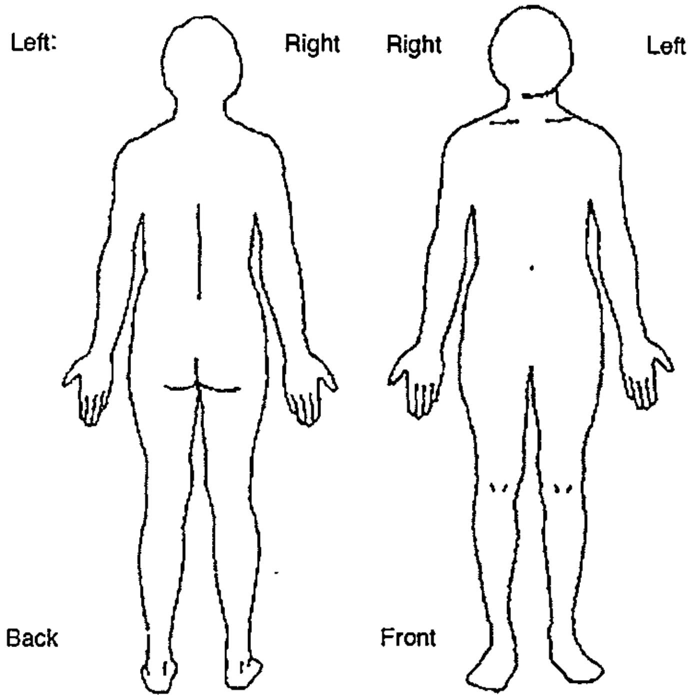
CBJD Spine Initial Intake Form Name ______________________ Date __________

Please mark the areas where you experience the following sensations:

Ache ^^^ Numbness ooo Pins & Needles === Burning XXX Stabbing ///



Vitals:

BP: ____/____ HR:______ WT:______ HT:________

Allergies:

____

Allergies to non-medications (shell-fish, latex, etc.)

____

____

Pain Medications (Circle ones to be refilled)	Strength (eg. mg)	Daily Dose	Pain Relief?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

How Bad Is Your Pain? Place an "X" (– – – X – – –) on each of the lines below to indicate your current pain level

How bad is your low back pain?

No pain– Worst Possible

How bad is your leg pain?

No pain– Worst Possible

How bad is your middle back pain?

No pain– Worst Possible

How bad is your neck pain?

No pain– Worst Possible

How bad is your arm pain?

No pain– Worst Possible

Center for Bone and Joint Disease Spine Initial Intake Form Name____________________

Describe Your Problem:

Main Complaint ____

☐ I don't know how it began ☐ It comes and goes ☐ I've had it for a long time (______ years)

☐ Injury (date of injury ________) Please explain how injury occurred ______________________

On the job? ☐ Yes ☐ No Have you been laid off from your job? ☐ Yes ☐ No

Are you currently in litigation with regards to your back pain? ☐ Yes ☐ No

Any symptoms prior to the injury? ☐ Yes ☐ No

Do you have any of the following?

Is your pain worse at night? ☐ Yes ☐ No

Does your pain awaken you at night? ☐ Yes ☐ No

Does coughing affect your pain? ☐ Yes ☐ No

Do you have any of the following?

☐ Fever ☐ Chills ☐ Night Sweats

☐ Recent Weight Loss >10 lbs ☐ Recent Weight Gain >10 lbs

Do your legs hurt/tire when you walk? ☐ Yes ☐ No

If YES, how far can you walk?

☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks

Do you have problems with balance? ☐ Yes ☐ No

Difficulty buttoning your shirt/blouse? ☐ Yes ☐ No

Changes in writing ability? ☐ Yes ☐ No

Bladder Control (Urine):

☐ No problem ☐ Can't empty bladder ☐ Loss of urine (accidents)

Bowel Control:

☐ No problem ☐ Constipation ☐ Loss of control (accidents)

Do you have any of the following?

Sitting	☐ Better	☐ Worse	☐ No Change
Standing	☐ Better	☐ Worse	☐ No Change
Walking	☐ Better	☐ Worse	☐ No Change
Lying Down	☐ Better	☐ Worse	☐ No Change
Rising from chair	☐ Better	☐ Worse	☐ No Change
Physical activity	☐ Better	☐ Worse	☐ No Change
Heat	☐ Better	☐ Worse	☐ No Change
Cold	☐ Better	☐ Worse	☐ No Change

Center for Bone and Joint Disease Spine Initial Intake Form   Name________________________

Do You Have a History of?

☐ Vascular problems/Peripheral Vascular Disease   ☐ Diabetes   ☐ Neuropathy

☐ Bleeding problems   ☐ Family History of Bleeding problems   ☐ Osteoporosis

☐ Stomach Ulcer   ☐ Hepatitis/Cirrhosis   ☐ Kidney Stones/Infection

☐ Rheumatoid Arthritis   ☐ Gout   ☐ Active Infection

☐ Heart Disease   ☐ History of Pacemaker

☐ Smoking -- If YES,   I smoke ______ packs/day and I have smoked for _____ years

Or did I smoke _____ packs/day for _____ years, but I quit smoking _____ years ago

☐ Cancer -- If YES, What type?________________________________

☐ Have you used Immuno-suppression or corticosteroids? (circle which one)

Previous Treatment

We need to know about the treatments you have already received for your current back/neck pain.

If YES, did the treatment make your condition better or worse?   Dates of Treatment

Chiropractic care	☐ better	☐ worse	______________________
Physical therapy	☐ better	☐ worse	______________________
Injections	☐ better	☐ worse	______________________
Psychological consultation	☐ better	☐ worse	______________________

For your current back/neck pain, please mark the boxes for the timeframe any tests were done.

	< 6 Months	> 12 months
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Have you ever had surgery on your neck or back?

☐ Yes   ☐ No   If Yes, complete the following

1) Type of Surgery ________________________
Date ________________________
Surgeon ________________________
Did it make your pain ☐ better or ☐ worse?

2) Type of Surgery ________________________
Date ________________________
Surgeon ________________________
Did it make your pain ☐ better or ☐ worse?

3) Type of Surgery ________________________
Date ________________________
Surgeon ________________________
Did it make your pain ☐ better or ☐ worse?

4) Type of Surgery ________________________
Date ________________________
Surgeon ________________________
Did it make your pain ☐ better or ☐ worse?

Patient's Name ______________________ Number ________ Date ____________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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

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

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter 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.

Section 5 – 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.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score ___x 2) / (___ Sections x10) = __________% ADL______

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments ______________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook, Roland, Jenner (eds.), Back Pain New Approaches to Rehabilitation Education. Manchester Univ Press, Manchester 1989: 187-204.

Patient's Name______________________ Number__________ Date ______________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worse imaginable at the moment.

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

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

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score ___x 2) / (___ Sections x10) = ____________% ADL______

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ 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.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless)

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usually recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments ______________________

%ADL

Reference: Vernon,, Mior. JMPT 1991; 14(7): 409-15