

# RAPID ACCESS CLINIC LOW BACK PAIN



## PATIENT INTAKE

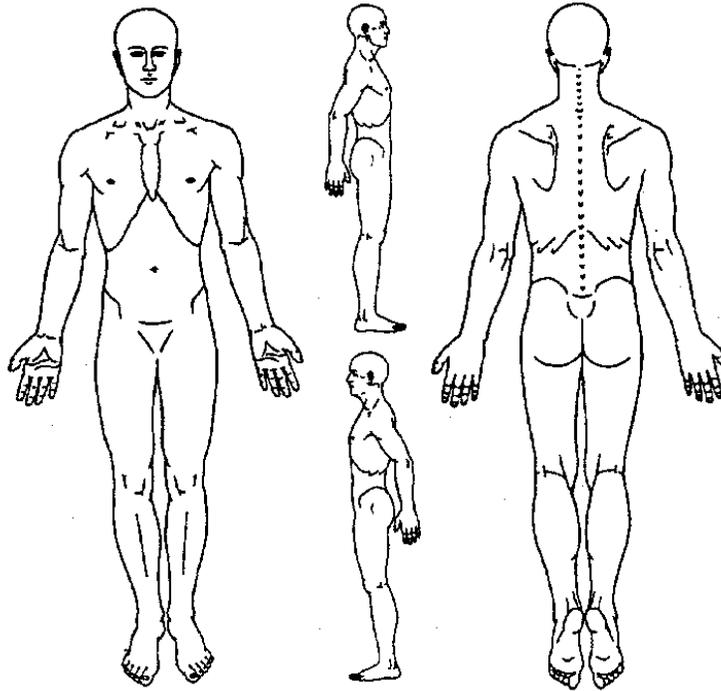
Date: dd/mm/yy

<b>Patient Information</b>						
Name:		OHIP#:				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Date of Birth: dd/mm/yy	Phone:			
Address:		City:				
Email:		Postal Code:				
<b>Back Specific History</b>						
Where has your pain been the worst? (mark one) <input type="checkbox"/> Back <input type="checkbox"/> Leg <input type="checkbox"/> Equal						
Does the pain stop completely, even for a moment? <input type="checkbox"/> Yes <input type="checkbox"/> No						
During the <u>past week</u> , how bothersome have these symptoms <u>been</u> :						
	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back and/or buttock pain	<input type="checkbox"/>					
Leg pain	<input type="checkbox"/>					
Numbness or tingling in leg	<input type="checkbox"/>					
Weakness in the leg and/or foot	<input type="checkbox"/>					
How long have you had your current episode of low back related symptoms?						
<input type="checkbox"/> < 6 weeks <input type="checkbox"/> 6 – 12 weeks <input type="checkbox"/> 3 – 6 months <input type="checkbox"/> 6 – 12 months <input type="checkbox"/> > 12 months <input type="checkbox"/> N/A						
Is your pain: <input type="checkbox"/> Improving <input type="checkbox"/> Staying the same <input type="checkbox"/> Worsening						
Have you had back problems before your current episode of back symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No						
What makes your symptoms better? (mark all that apply)						
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Bending Forwards						
<input type="checkbox"/> Medication <input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Stretching <input type="checkbox"/> Exercise <input type="checkbox"/> Bending Backwards						
<input type="checkbox"/> Sessions with a physio/chiro etc. <input type="checkbox"/> Other. Please specify _____						
What makes your symptoms worse? (mark all that apply)						
<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Bending Forwards <input type="checkbox"/> Bending Sideways						
<input type="checkbox"/> Lifting <input type="checkbox"/> Inactivity <input type="checkbox"/> Coughing <input type="checkbox"/> Sneezing <input type="checkbox"/> Bending Backwards						
<input type="checkbox"/> Other. Please specify: _____						
Have you had any changes in your bowel or bladder function since the start of your low back symptoms?						
<input type="checkbox"/> No <input type="checkbox"/> Yes. Describe: _____						
Because of your back problem, have you been, or are you currently involved with: (mark all that apply)						
<input type="checkbox"/> Legal Action <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Workers Compensation <input type="checkbox"/> No Claim						

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**Pain Diagram - Please mark the area of injury or discomfort on the chart below**



Indicate below how you would rate your average pain level during the past week in your back and leg(s) (as applicable), ranging from 'No pain' to 'Worst possible pain you can imagine'.

**Back pain at its best:**

0  1  2  3  4  5  6  7  8  9  10   
*No pain* *Worst possible pain*

**Back pain at its worst:**

0  1  2  3  4  5  6  7  8  9  10   
*No pain* *Worst possible pain*

**Leg pain at its best:**

0  1  2  3  4  5  6  7  8  9  10   
*No pain* *Worst possible pain*

**Leg pain at its worst:**

0  1  2  3  4  5  6  7  8  9  10   
*No pain* *Worst possible pain*

**How long can you comfortably?**

<b>Activity:</b>	<b>Sit</b>	<b>Stand</b>	<b>Walk</b>	<b>Sleep</b>
<b>Time:</b>	_____ mins	_____ mins	_____ mins	_____ hrs

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What medication(s) do you take for your pain and how often do you take them?

Name of Drug	Dose	How many per day?	When did you start taking them?
<input type="checkbox"/> None			
<input type="checkbox"/> Tylenol or other over the counter drugs			
<input type="checkbox"/> Prescription Anti-Inflammatory			
<input type="checkbox"/> Tylenol #3 or #4			
<input type="checkbox"/> Percocet			
<input type="checkbox"/> Oxycontin or Morphine			
<input type="checkbox"/> Hydromorphone/Dilaudid			
<input type="checkbox"/> Other: _____			

Have you had any surgery for your back problems?  No  Yes. Please describe: \_\_\_\_\_

Have you had any investigations for your back problem?  No  Yes. See below

	<input type="checkbox"/> X-ray	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> Bone scan	<input type="checkbox"/> EMG
Date of Investigation:					

Have you tried any treatments for your pain? Mark which apply

Treatment	Helpful	No Benefit
<input type="checkbox"/> Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Massage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>

How often do you exercise? (e.g. 20 minutes or more of nonstop activity)

Never, due to low back pain  Never  Once or less per week  Twice or more per week

Employment Status:

Currently Working  Modified Duties  Student  Other: \_\_\_\_\_  
 Not Employed  On Disability Benefits  Retired

If employed, what do you do for work? \_\_\_\_\_

Does the nature of your work involve? (Mark all that apply)

Sitting  Standing  Walking  Lifting  Carrying  Bending  Twisting  
 Driving  Other. Please specify: \_\_\_\_\_

I have support from people who can assist me with activities in the home, work or community? (check one)

Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree

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Medical History. Please indicate if you are currently being treated for any of the following conditions:

Conditions (mark all that apply)	Does it limit your function?	Conditions (mark all that apply)	Does it limit your function?
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Heart Attack/Coronary Artery Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Ulcer or Stomach Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Lung Disease (e.g. asthma, COPD)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Anaemia or Other Blood Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Chronic Neck Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Dementia	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Osteoarthritis/Degenerative Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Chronic Pelvic Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> No <input type="checkbox"/> Yes

Other Medical Problems (please specify): \_\_\_\_\_  No  Yes

Please list **current prescribed** medications:

\_\_\_\_\_

\_\_\_\_\_

Please list **previous surgeries**: \_\_\_\_\_

\_\_\_\_\_

Do you have any **drug allergies**?  No  Yes. Describe \_\_\_\_\_

Do you **smoke**?  No  Yes. How much? \_\_\_\_\_  Quit. When? \_\_\_\_\_

What results do you hope to achieve from your visit today? (Mark one response on each line)

	Not at all likely	Slightly likely	Somewhat likely	Very likely	Extremely likely	Not applicable
Relief from symptoms	<input type="checkbox"/>					
To do more everyday household or yard activities	<input type="checkbox"/>					
To sleep more comfortably	<input type="checkbox"/>					
To go back to my usual job	<input type="checkbox"/>					
To exercise and do recreational activities	<input type="checkbox"/>					
To prevent future disability	<input type="checkbox"/>					

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### PATIENT INTAKE

Date: dd/mm/yy

### ODI

**DIRECTIONS:** Answer every question by marking the correct box. If you need to change an answer, completely scratch out the incorrect answer and mark the correct box. If you are unsure about how to answer a question, please give the best answer you can. Mark only one answer for each question unless instructed otherwise.

<p><b>1. PAIN INTENSITY:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I have no pain at the moment.</li> <li><input type="checkbox"/> The pain is very mild at the moment.</li> <li><input type="checkbox"/> The pain is moderate at the moment.</li> <li><input type="checkbox"/> The pain is fairly severe at the moment.</li> <li><input type="checkbox"/> The pain is very severe at the moment.</li> <li><input type="checkbox"/> The pain is the worst imaginable at the moment.</li> </ul>	<p><b>6. STANDING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without extra pain.</li> <li><input type="checkbox"/> I can stand as long as I want but it gives extra pain.</li> <li><input type="checkbox"/> Pain prevents me from standing more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from standing more than 1/2 an hour.</li> <li><input type="checkbox"/> Pain prevents me from standing more than 10 minutes.</li> <li><input type="checkbox"/> Pain prevents me from standing at all.</li> </ul>
<p><b>2. PERSONAL CARE (WASHING, DRESSING, ETC):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can look after myself normally without causing extra pain.</li> <li><input type="checkbox"/> I can look after myself normally but it is very painful.</li> <li><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</li> <li><input type="checkbox"/> I need some help but manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of self-care.</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</li> </ul>	<p><b>7. SLEEPING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sleep is never disturbed by pain</li> <li><input type="checkbox"/> My sleep is occasionally disturbed by pain.</li> <li><input type="checkbox"/> Because of pain I have less than 6 hours sleep.</li> <li><input type="checkbox"/> Because of pain I have less than 4 hours sleep.</li> <li><input type="checkbox"/> Because of pain I have less than 2 hours sleep.</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all.</li> </ul>
<p><b>3. LIFTING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without extra pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g on a table).</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift only very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul>	<p><b>8. SEX LIFE (if applicable):</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My sex life is normal and causes no extra pain.</li> <li><input type="checkbox"/> My sex life is normal but causes some extra pain.</li> <li><input type="checkbox"/> My sex life is nearly normal but is very painful.</li> <li><input type="checkbox"/> My sex life is severely restricted by pain</li> <li><input type="checkbox"/> My sex life is nearly absent because of pain.</li> <li><input type="checkbox"/> Pain prevents any sex life at all.</li> </ul>
<p><b>4. WALKING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from walking any distance.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1 mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1/2 mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1/4 mile.</li> <li><input type="checkbox"/> I can only walk using a stick or crutches.</li> <li><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</li> </ul>	<p><b>9. SOCIAL LIFE:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and causes me no extra pain.</li> <li><input type="checkbox"/> My social life is normal but increases the degree of pain.</li> <li><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, sports)</li> <li><input type="checkbox"/> Pain has restricted my social life and I do not go out as often.</li> <li><input type="checkbox"/> Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> I have no social life because of pain</li> </ul>
<p><b>5. SITTING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like.</li> <li><input type="checkbox"/> I can only sit in my favourite chair as long as I like.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 1/2 an hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes.</li> <li><input type="checkbox"/> Pain prevents me from sitting at all.</li> </ul>	<p><b>10. TRAVELLING:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without pain.</li> <li><input type="checkbox"/> I can travel anywhere but it gives extra pain.</li> <li><input type="checkbox"/> Pain is bad but I manage journeys over two hours.</li> <li><input type="checkbox"/> Pain restricts me to journeys less than one hour.</li> <li><input type="checkbox"/> Pain restricts me to short journeys under 30 minutes.</li> <li><input type="checkbox"/> Pain prevents me from traveling except to receive treatment</li> </ul>

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### PATIENT INTAKE

#### EQ-5D

Date: dd/mm/yy

Under each heading, please tick the **ONE** box that best describes your health **TODAY**:

#### MOBILITY:

- I have no problems walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

#### SELF-CARE:

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

#### USUAL ACTIVITIES (eg., work, study, housework, family or leisure activities):

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

#### PAIN/DISCOMFORT:

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

#### ANXIETY/DEPRESSION:

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

### STarT Back

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree	Agree
	0	1
1. My back pain has <b>spread down my leg(s)</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2. I have had pain in the <b>shoulder</b> or <b>neck</b> at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3. I have only <b>walked short distances</b> because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4. In the last 2 weeks, I have <b>dressed more slowly</b> than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5. It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Worrying thoughts</b> have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7. I feel that <b>my back pain is terrible</b> and <b>it's never going to get any better</b>	<input type="checkbox"/>	<input type="checkbox"/>
8. In general, I have <b>not enjoyed</b> all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>
9. Overall, how <b>bothersome</b> has your back pain been in the <b>last 2 weeks</b> ?		
Not at all	Slightly	Moderately
Very much	Extremely	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0
1	1	1

Total score (all 9): \_\_\_\_\_ Sub Score (Q5-9): \_\_\_\_\_