



Back & Neck Pain Center

Experts in healing. Specialists in caring.



Patient Label



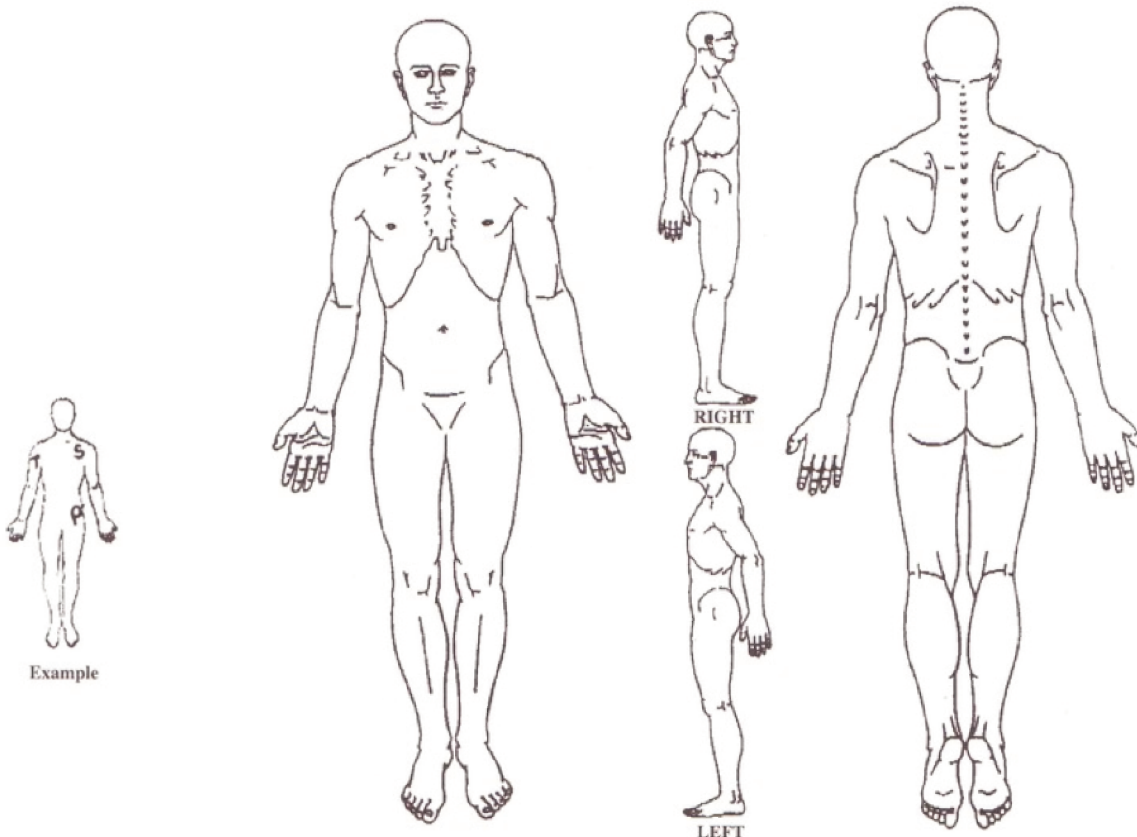
Name: _____ Home Phone: _____
 Address: _____ Cell Phone: _____
 DOB: _____ Age: _____ Sex: Male Female
 Emergency Contact: _____ Phone #: _____

Insurance Information

Primary Insurance: _____ ID#: _____
 Secondary Insurance: _____ ID#: _____

Current Condition and Symptoms: _____

Use the letters to indicate the type and location of your sensations right now:
 S=Stiffness B=Burning N=Numbness P=Sharp Pain T=Tingling D=Dull Pain

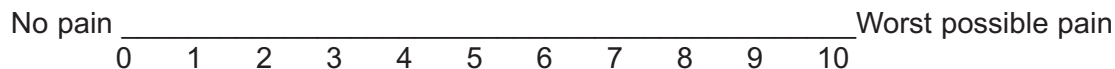


Patient Label

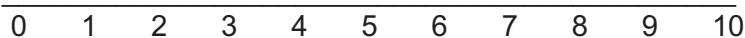
QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

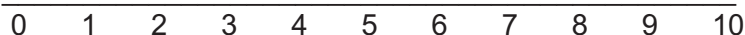
EXAMPLE:



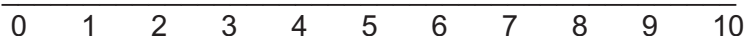
1. How would you rate your pain RIGHT NOW?



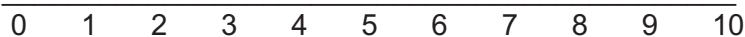
2. What is your typical or AVERAGE pain?



3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)



When did you first notice any symptoms? (Date of injury if known) _____

How did your condition begin? _____

Did you have an injury? Yes No. Explain _____

Is the pain keeping you from working? Yes No

Is this a workers compensation case? Yes No

Were you injured in a motor vehicle accident? Yes No

Is there a pending law suit? Yes No

Medications:

Include ALL prescription, over the counter, supplements and herbal products

Medication	Dosage	# Times Taken/Day	Reason for taking

Patient Label

Allergies: Do you have any allergies? (Including medication, food products, latex, etc.)

Yes No, **If yes**, please describe allergen & reaction _____

Have you ever had a reaction to any dye for a special test? Yes No, **If yes**, what type of test and reaction? _____

Surgical History:

Have you had any prior surgeries? Yes No, **If yes**:

Surgery _____	Date _____	Provider _____	Hospital _____
Surgery _____	Date _____	Provider _____	Hospital _____
Surgery _____	Date _____	Provider _____	Hospital _____
Surgery _____	Date _____	Provider _____	Hospital _____

Past Medical History:

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Bowel trouble | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Chronic Bronchitis/Emphysema |
| <input type="checkbox"/> Sexual/Psychological abuse | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Spine surgery | <input type="checkbox"/> Other | <input type="checkbox"/> Osteoporosis |

If you checked yes to any of the above, please explain: _____

Family Medical History:

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Bowel trouble | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Chronic Bronchitis/Emphysema |
| <input type="checkbox"/> Sexual/Psychological abuse | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Spine surgery | <input type="checkbox"/> Other | |

Patient Label

Imaging/tests:

Have you had any of the following imaging studies or tests for your current problem?

X-ray	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CT Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
EMG/Nerve Conduction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sonogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DEXA Scan	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above tests, please tell us where you had them done, when you had them done, and what the results were if you know them.

If you have the disc with the images and/or the report please provide us with a copy.

Facility where tests were performed: _____

Date of the tests: _____

Results: _____

Habits:

Do you use tobacco? Yes No, **If yes**, what form? _____ For how long? _____

Have you ever smoked? Yes No, **If yes**, how many cigarettes per day? _____

Do you use alcohol? Yes No, **If yes**, what type? _____ Frequency? _____

Sleep Pattern:

Has your sleeping pattern changed due to your pain? Yes No

Does your pain wake you up at night? Yes No

Does your pain make it difficult to fall asleep? Yes No

Which of the following factors make your pain better or worse? Please check all that apply.

Bending forwards	<input type="checkbox"/> better	<input type="checkbox"/> worse
Bending backwards	<input type="checkbox"/> better	<input type="checkbox"/> worse
Sitting	<input type="checkbox"/> better	<input type="checkbox"/> worse
Standing	<input type="checkbox"/> better	<input type="checkbox"/> worse
Climbing stairs	<input type="checkbox"/> better	<input type="checkbox"/> worse
Exercise	<input type="checkbox"/> better	<input type="checkbox"/> worse
Reaching	<input type="checkbox"/> better	<input type="checkbox"/> worse
Coughing or straining	<input type="checkbox"/> better	<input type="checkbox"/> worse
Bowel movements	<input type="checkbox"/> better	<input type="checkbox"/> worse
Lying down	<input type="checkbox"/> better	<input type="checkbox"/> worse
Pushing shopping carts	<input type="checkbox"/> better	<input type="checkbox"/> worse
Sexual relations	<input type="checkbox"/> better	<input type="checkbox"/> worse
Relaxation	<input type="checkbox"/> better	<input type="checkbox"/> worse

Patient Label

Radiating Factors:

Mark which best describes the pain in your back/leg or neck/arm.

FOR BACK PAIN

- Back pain only no leg pain
- Back pain worse than leg pain
- Back pain and leg pain equal
- Leg pain worse than back pain
- Leg pain only no back pain
- Leg pain worsens when I bend backwards
- Leg pain worsens when I bend forwards

FOR NECK PAIN

- Neck pain only no arm pain
- Neck pain worse than arm pain
- Neck pain and arm pain equal
- Arm pain worse than neck pain
- Arm pain only
- Arm pain worsens when I look up
- Arm pain worsens when I look down

Pain Characteristics:

Do you have numbness, tingling, or pins and needles in your hands, feet, arms, or legs? Yes No,
If yes where? _____

Do you have weakness of your muscles? Yes No, **If yes** where? _____

Is the pain constant or intermittent? Consistant Intermittent

Is the pain sharp or dull? Sharp Dull

Describe the pain _____

Have you ever been in the emergency room or urgent care for the pain? Yes No

Have you experienced loss of bowel or bladder function? Yes No

Have you experienced severe weakness of your arms and legs? Yes No

Have you noticed extreme clumsiness, stumbling, or difficulty in walking? Yes No

Have you experienced numbness all over your body? Yes No

Have you experienced a recent fever or infection? Yes No

Is your pain unrelieved by rest, and/or when you go to sleep at night? Yes No

Please mark what other treatments you have tried? Where they helpful?

Pain Management and Treatment

- | | |
|---|---|
| <input type="checkbox"/> Epidural Injections | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Facet Blocks | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Sacroiliac Blocks | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Trigger Point Injections | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Radiofrequency Ablation | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain Pump | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Spinal Cord Stimulator | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Chiropractic Care

- | | |
|--|---|
| <input type="checkbox"/> Exercises | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Physical Therapy | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Massage | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Electrical Stimulation (TENS) | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Acupuncture | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Heating pack | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ice pack | Helpful? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Patient Label

Physical Therapy

- Exercises Helpful? Yes No
- Physical Therapy Helpful? Yes No
- Massage Helpful? Yes No
- Electrical Stimulation (TENS) Helpful? Yes No
- Acupuncture Helpful? Yes No
- Heating pack Helpful? Yes No
- Ice pack Helpful? Yes No

Other

- Pilates Helpful? Yes No
- Tai Chi Helpful? Yes No
- Psychotherapy Helpful? Yes No
- Aquatherapy Helpful? Yes No
- Surgery Helpful? Yes No
- Aromatherapy Helpful? Yes No
- Relaxation/meditation Helpful? Yes No
- Massage Helpful? Yes No
- Yoga Helpful? Yes No

If you checked YES to any of the above questions, please tell us which providers you have seen, and when the procedure or treatment was done

Patient Signature: _____ Date: _____ Time: _____



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BN7660

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone #: _____

MR# _____

Persons/Organizations authorized to disclose my information:

John T. Mather Memorial Hospital, Back & Neck Pain Center and Outpatient Treatment Provider

Specific description of information to be disclosed to outpatient treatment provider from Back & Neck Pain Center:

Consult note, clinical progress report, progress notes clinical summary and treatment request, provider, correspondence, imaging studies, diagnostic studies, laboratory results (inclusive of all dates while under care.)

Specific description of information to be disclosed from outpatient treatment provider to Back & Neck Pain Center:

Consult note, last 5 progress notes, list of all medications, imaging studies, diagnostic studies, laboratory results, hospital discharge reports (inclusive of all dates while under care.)

Description of the purpose of the disclosure of my patient information:

Coordination of treatment and navigation.

1. I understand that this authorization will expire on ___/___/_____ or in 12 months from the date listed below.
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.
3. I understand that I may revoke this authorization at any time by notifying the providing organization disclosing my patient information in writing, but if I do, the revocation will not have any effect on actions the organization has already taken in reliance on this authorization.

This form MUST be completed before signing.

(Signature of patient 18 years older / patient's representative)

Date

Time

(Parent or Guardian)

Date

Time

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION TO AND FROM OUTPATIENT TREATMENT PROVIDER



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BN7655

I authorize contact from the Back & Neck Pain Center to **confirm my appointment and/or billing information** via: (Please select all that apply)

- Cell Phone Home Phone Work Phone Fax Email Any of the Above

I authorize **health information** to be provided to me via: (Please select all that apply)

- Cell Phone Home Phone Work Phone Fax Email Any of the Above

I authorize that a **message may be left with another member** of my household.

Name of Person: _____ Relationship: _____

I **do not authorize** communication in any manner except in person.

Please fill-in the following communication methods of which you authorize the Back & Neck Pain Center to utilize:

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Fax #: _____

Email Address: _____

(Printed Name of Patient)

(Date)

(Time)

(Signature of Patient/Legal Representative)

(Date)

(Time)



Patient Label



Patient Name (Print): _____

Date: _____ Time: _____

Please answer each section marking one box that most applies to you.

Section 1. Pain Intensity:

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain severe and does not vary much.

Section 2. Personal Care:

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes me pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing or dressing without help.

Section 3. Lifting: (Skip if you have no attempted lifting since the onset of your low back pain).

- I can lift heavy weights without extra low back pain.
- I can lift heavy weights but it causes me extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- 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 only lift light weights at the most.

Section 4. Walking:

- I have no pain walking.
- I have some pain walking, but I can still walk my required to normal distances.
- Pain prevents me from walking long distances.
- Pain prevents me from walking intermediate distances.
- Pain prevents me from walking even short distances.
- Pain prevents me from walking at all.

Section 5. Sitting:

- Sitting does not cause me any pain.
- I can sit for as long as I need provided I have my choice of sitting surfaces.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6. Standing:

- I can stand as long as I want without any pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

Section 7. Sleeping:

- I have no pain while in bed.
- I have pain in bed, but it does not prevent me from sleeping well.
- Because of pain I only sleep 3/4 of normal time.
- Because of pain I only sleep 1/2 of normal time.
- Because of pain I only sleep 1/4 of normal time.
- Pain prevents me from sleeping at all.

Section 8. Social Life:

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities (i.e. sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of pain.

Section 9. Traveling:

- I have no pain while traveling.
- I have some pain while traveling, but none of my usual forms of travel make it any worse.
- I have some pain while traveling, but it does not compel me to seek alternative forms of travel.
- I have extra pain while traveling that requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain restricts all forms of travel except that done lying down.

Section 10. Employment/Homemaking:

- My normal job/homemaking duties do not cause pain.
- My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- I can preform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (i.e. lifting, vacuuming, etc).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from even light duties.
- Pain prevents me from performing any job or homemaking chores.



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BN7605

Patient Name: _____ Date: _____ Time: _____
(print)

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

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some point in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some point in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly 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 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back or neck pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things that I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9 Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all

0

Slightly

0

Moderately

0

Very Much

1

Extremely

1

Total Score (all 9): _____

Sub Score (Q5-9): _____



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Patient Label


BN7600

Patient Name: _____ Date: _____ Time: _____
(print)

Please answer each section marking one box that most applies to you.

Section 1. Pain Intensity:

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

Section 2. Personal Care:

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

Section 3. Lifting:

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

Section 4. Reading:

- A. I can read as much as I want to, with no pain in my neck.
- B. I can read as much as I want to, with slight pain in my neck.
- C. I can read as much as I want to, with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I can hardly read as much at all because of severe pain.
- F. I cannot read at all.

Section 5. Headaches:

- A. I have no headaches at all.
- B. I have slight headaches, which come infrequently.
- C. I have moderate headaches, which come infrequently.
- D. I have moderate headaches, which come frequently.
- E. I have severe headaches, which come infrequently.
- F. I have headaches almost all the time.

Section 6. Concentration:

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

Section 7. Work:

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

Section 8. Driving:

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

Section 9. Sleeping:

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10. Recreation:

- A. I am able to engage in all my recreation activities with no neck pain at all.
- B. I am able to engage in all my recreation activities with some pain in my neck.
- C. I am able to engage in most, but not all, of my recreation activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
- E. I can hardly do any recreation activities because of pain in my neck.
- F. I cannot do any recreation activities at all.

NECK PAIN DISABILITY INDEX

Score _____ / _____