MATHER HOSPITAL
John T. Mather Memorial

Back & Neck Pain Center

Experts in healing. Specialists in caring.

Patient Label

BN7630

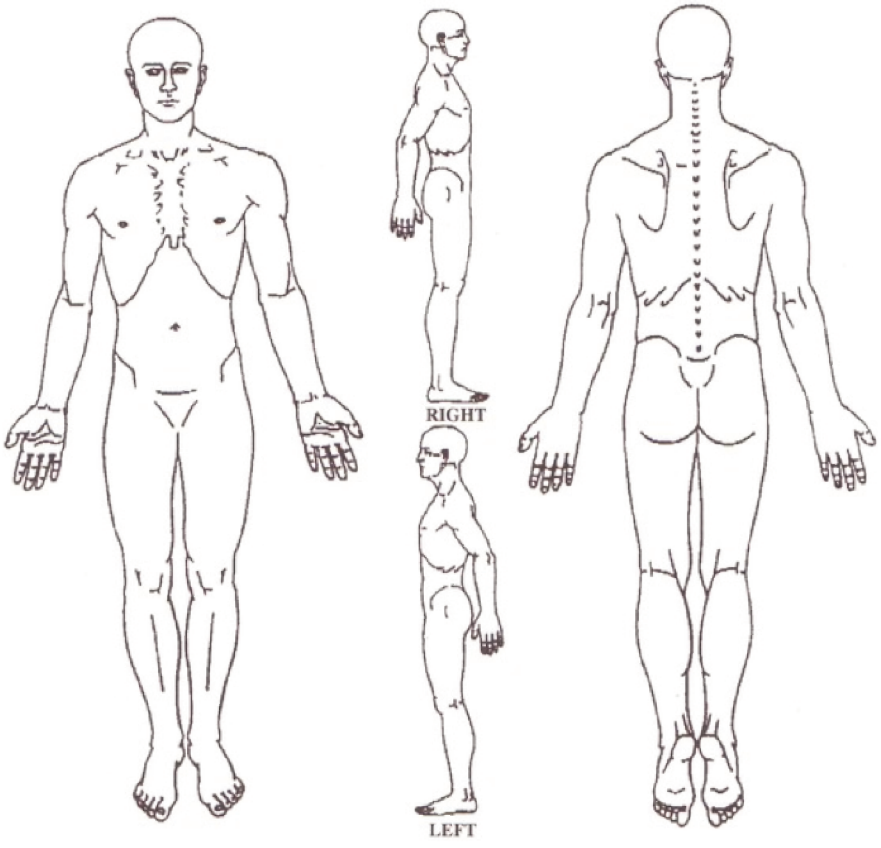
Name:_____ **Home Phone:**_____
Address:_____ **Cell Phone:**_____
DOB:_____ **Age:**_____ **Sex: ❑ Male ❑ Female**
Emergency Contact:_____ **Phone #:**_____

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

Example



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:

No pain _____Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

---

1. How would you rate your pain RIGHT NOW?

_____

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

_____

0 1 2 3 4 5 6 7 8 9 10

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

_____

0 1 2 3 4 5 6 7 8 9 10

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

_____

0 1 2 3 4 5 6 7 8 9 10

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

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:

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

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

_____

_____

_____

_____

Family Medical History:

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

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

X-ray	❑ Yes ❑ No
CT Scan	❑ Yes ❑ No
MRI	❑ Yes ❑ No
Discogram	❑ Yes ❑ No
Bone Scan	❑ Yes ❑ No
EMG/Nerve Conduction	❑ Yes ❑ No
Sonogram	❑ Yes ❑ No
DEXA Scan	❑ Yes ❑ 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	❑ better	❑ worse
Bending backwards	❑ better	❑ worse
Sitting	❑ better	❑ worse
Standing	❑ better	❑ worse
Climbing stairs	❑ better	❑ worse
Exercise	❑ better	❑ worse
Reaching	❑ better	❑ worse
Coughing or straining	❑ better	❑ worse
Bowel movements	❑ better	❑ worse
Lying down	❑ better	❑ worse
Pushing shopping carts	❑ better	❑ worse
Sexual relations	❑ better	❑ worse
Relaxation	❑ better	❑ 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
- ❑ Epidural Injections — Helpful? ❑ Yes ❑ No
- ❑ Facet Blocks — Helpful? ❑ Yes ❑ No
- ❑ Sacroiliac Blocks — Helpful? ❑ Yes ❑ No
- ❑ Trigger Point Injections — Helpful? ❑ Yes ❑ No
- ❑ Radiofrequency Ablation — Helpful? ❑ Yes ❑ No
- ❑ Pain Pump — Helpful? ❑ Yes ❑ No
- ❑ Spinal Cord Stimulator — Helpful? ❑ Yes ❑ No

Chiropractic Care
- ❑ 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

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:_____

MATHER HOSPITAL

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Patient Label

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

MATHER HOSPITAL

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Patient Label

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)

COMMUNICATION CONSENT

MATHER HOSPITAL **Back & Neck Pain Center**
Experts in healing. Specialists in caring.

Patient Label

BN7615

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 thought 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.

MODIFIED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Score_____/_____

MATHER HOSPITAL
John T. Mather Memorial

Back & Neck Pain Center

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Patient Label

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	❑	❑
2	I have had pain in the **shoulder** or **neck** at some point in the last 2 weeks	❑	❑
3	I have only **walked short distances** because of my back pain	❑	❑
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	❑	❑
5	It's not really safe for a person with a condition like mine to be physically active	❑	❑
6	**Worrying thoughts** have been going through my mind a lot of the time	❑	❑
7	I feel that **my back** or **neck pain is terrible** and **it's never going to get any better**	❑	❑
8	In general I have **not enjoyed** all the things that I used to enjoy	❑	❑

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

Not at all	Slightly	Moderately	Very Much	Extremely
❑ 0	❑ 0	❑ 0	❑ 1	❑ 1

Total Score (all 9):_____ **Sub Score (Q5-9):**_____

The Keel STarT Back Screening Tool