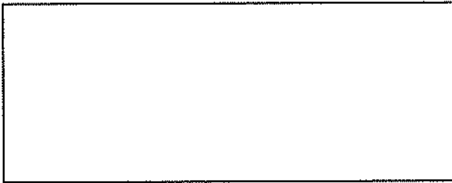
Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777



Any Change in your health, or NEW problems? ☐ Yes ☐ No

Current Condition and Symptoms: ______________________________

____

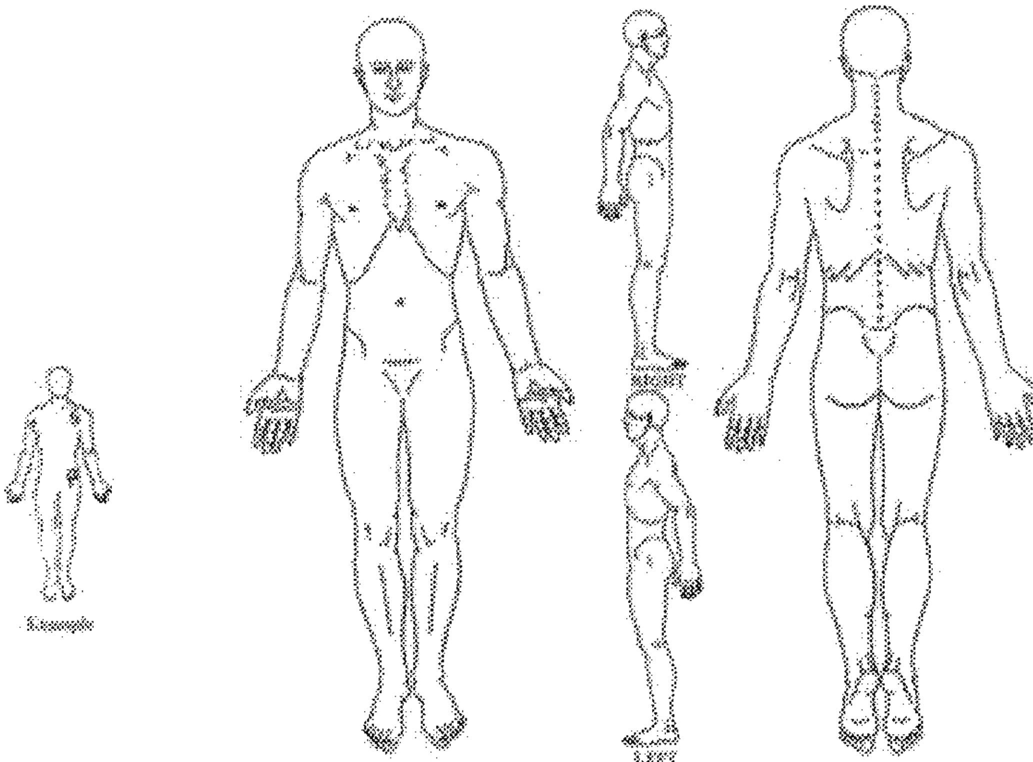
____

____

____

____

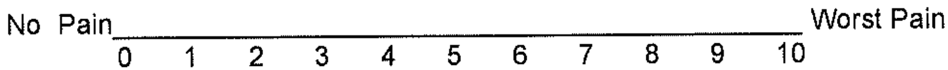
Use the letters to indicate the type and location of your sensations right now:
S=Stiffness B=Burning N=Numbness P=Sharp Pain T=Tingling D=Dull Pain



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.

1. How would you rate your pain RIGHT NOW?



Medications:

Please list any CHANGES to your medication list below: ❑ **No Changes**

Medication	Dosage	# Times Taken/Day	Reason for taking

Pain Characteristics:

Do any positions or activities make your pain better or worse? Please list below:

Better: ______________________________

Worse: ______________________________

Please check the box that best describes the pain you are experiencing.

For Back or Leg 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

For Neck or Arm 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

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 your pain: ______________________________

Have you ever been in the emergency room or urgent care for the pain since your last appointment?
❑ Yes ❑ No

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

I hereby consent to physical examination, referral to diagnostic imaging, and/or specialists deemed medically necessary by the BNPC nurse practitioner.

Patient Signature: ____ Date:__________ Time:__________

Back & Neck Pain Center

Experts in healing. Specialists in caring.

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 is moderate and does not vary much.
☐ The pain comes and goes and is severe.
☐ The pain is 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 not 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 sifting 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 are done lying down.

Section 10. Employment/Homemaking:

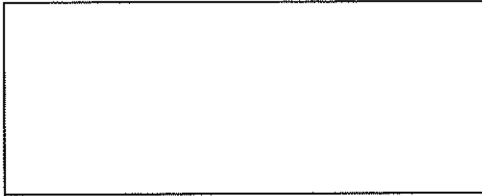
☐ My normal job/homemaking duties do not cause pain.
☐ My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (i.e. lifting, vacuuming, 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.

Score_______/_______

MODIFIED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Back & Neck Pain Center

Experts in healing. Specialists in caring.



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.
- ☐ G. 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 I hour sleepless).
- ☐ G. 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_____/_____

Mather Hospital
Northwell Health

Back & Neck Pain Center

Patient Satisfaction Survey

NAME____DATE______________________

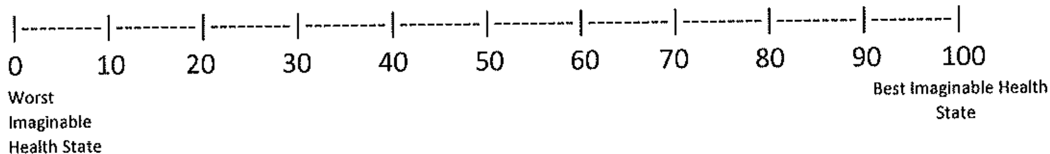
Thank you for taking the time to fill out this survey. Your feedback helps us provide a better service.

PLEASE CIRCLE ONE OF THE FOLLOWING: New Patient / Returning Patient

1. PLEASE RATE YOUR OVERALL CLINICAL PROGRESS:
   a. Pain: What percentage of improvement have you made thus far? ________%
   b. Function: What can you do more of now that you couldn't before you started care?
      - ______________________
      - ______________________
   c. Function: How much improvement have you made in these activities? _________%
   d. Quality of Life: What percentage of improvement have you made thus far? _________%

2. PLEASE INDICATE WHICH STATEMENTS BEST DESCRIBE YOUR OWN HEALTH TODAY:
   a. Mobility
      - I have no problems in walking about ☐
      - I have some problems in walking about ☐
      - I am confined to bed ☐
   b. Self-care
      - I have no problems with self-care ☐
      - I have some problems washing or dressing myself ☐
      - I am unable to wash or dress myself ☐
   c. Usual Activities *(e.g. work, study, housework, family, or leisure activities)*
      - I have no problems with performing my usual activities ☐
      - I have some problems with performing my usual activities ☐
      - I am unable to perform my usual activities ☐
   d. Pain/Discomfort
      - I have no pain or discomfort ☐
      - I have moderate pain or discomfort ☐
      - I have extreme pain or discomfort ☐
   e. Anxiety/Depression
      - I am not anxious or depressed ☐
      - I am moderately anxious or depressed ☐
      - I am extremely anxious or depressed ☐

3. PLEASE INDICATE ON THE FOLLOWING SCALE HOW GOOD OR BAD YOUR OWN HEALTH IS TODAY, IN YOUR OPINION:



PLEASE RATE EACH QUESTION: 5 (VERY GOOD), 4 (GOOD), 3 (FAIR), 2 (POOR), 1 (VERY POOR).

4. PLEASE RATE YOUR VISITS AND CARE WITH PROVIDERS WE REFERRED YOU TO:
   a. Please rate your overall experience with the providers to which you were referred. For each provider, list their name and rate them
      - Provider:________________________ 5 4 3 2 1
      - Provider:________________________ 5 4 3 2 1
5. HOW WOULD YOU RATE OUR INSTRUCTION ON SELF-CARE FOR THIS EPISODE & PREVENTING FUTURE RECURRENCES? 5 4 3 2 1
6. YOUR OVERALL SATISFACTION WITH THE BACK AND NECK PAIN CENTER IS: 5 4 3 2 1
7. WOULD YOU RECOMMEND THE BACK AND NECK PAIN CENTER TO OTHERS? Yes No