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

BN7630

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

DOB:_____ Age:_____ Sex assigned at birth: ❑ Male ❑ Female

Occupation:_____ Gender Identity:_____

Current Condition and Symptoms: _____

_____

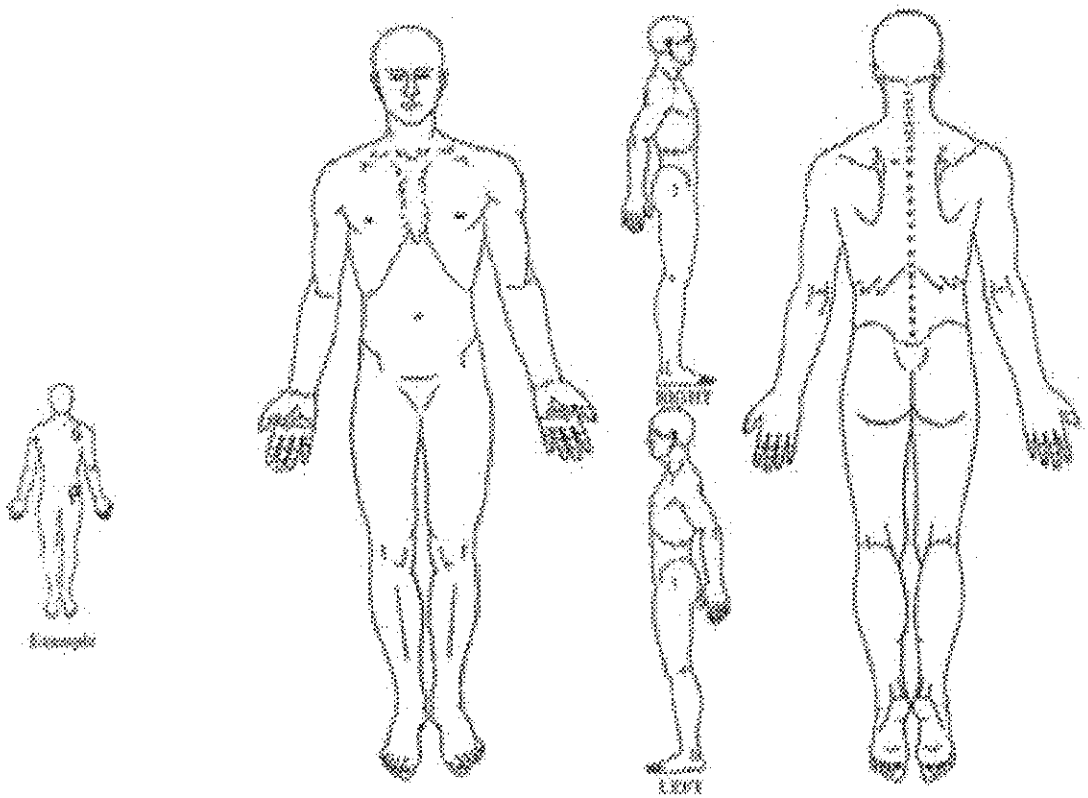
_____

_____

_____

_____

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?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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:
Please 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

Past Medical History:

❑ Diabetes
❑ High Blood Pressure
❑ High Cholesterol
❑ Stroke/TIA
❑ Heart Attack
❑ Heart Disease
❑ Heart Failure
❑ Kidney disease
❑ Liver disease
❑ Osteoporosis
❑ COPD
❑ Seizures
❑ Hepatitis A, B or C
❑ HIV/AIDS
❑ GERD
❑ Bowel trouble (specify below)
❑ Migraines
❑ Thyroid disease
❑ Bleeding disorder
❑ Cancer (specify type below)
❑ Psychiatric condition (specify)
❑ Other (specify below)
❑ Alcohol abuse
❑ Drug abuse
❑ Arthritis
❑ Spine surgery
❑ Multiple Sclerosis
❑ Lupus
❑ Fibromyalgia
❑ Depression
❑ Anxiety
❑ Asthma

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

_____

Family Medical History:
Please check the box next to any of the conditions with which a family member has been diagnosed and state relationship below:

❑ Diabetes
❑ Heart disease
❑ Stroke/TIA
❑ High Blood Pressure
❑ Psychiatric condition (specify)
❑ Lung disease
❑ Arthritis
❑ Genetic condition
❑ Cancer (specify type below)
❑ Other (specify below)

_____

_____

Imaging/tests:
Check the box next to any of the following imaging studies or tests for your current problem:

❑ X-ray ❑ CT Scan ❑ MRI ❑ Discogram ❑ Bone Scan
❑ EMG/Nerve Conduction ❑ Sonogram ❑ DEXA Scan ❑ Other

Facility where tests were performed, date of exam, and results if known:_____

_____

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? _____
Do you use recreational drugs? ❑ 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

Height: _____ **Weight:** _____

How do the following factors affect your pain? Please check the best response.

Activity	Makes Pain Better	Makes Pain Worse	No Change/Unsure
Bending forwards			
Bending backwards			
Sitting			
Standing			
Climbing Stairs			
Reaching			
Coughing or straining			
Bowel Movements			
Lying Down			
Pushing Shopping Carts			
Relaxation			

Pain Characteristics:
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? ❑ Yes ❑ No
Have you experienced loss of bowel or bladder function? ❑ Yes ❑ No
Have you noticed extreme clumsiness, stumbling, or difficulty in walking? ❑ Yes ❑ No
Have you experienced a recent fever or infection? ❑ Yes ❑ No

Pain Treatment:

If you have had treatment in the past, please tell us the type, which providers you have seen, and when the treatment or procedure took place. Was the treatment helpful?

_____
_____
_____

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:_____

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

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 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

MATHER HOSPITAL **Back & Neck Pain Center**

Experts in healing. Specialists in caring.

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.
- ☐ 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 **Back & Neck Pain Center**
Experts in healing. Specialists in caring.

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

MATHER HOSPITAL

Back & Neck Pain Center

Experts in healing. Specialists in caring.

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.

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