



Back & Neck Pain Center

Experts in healing. Specialists in caring.



Patient Label



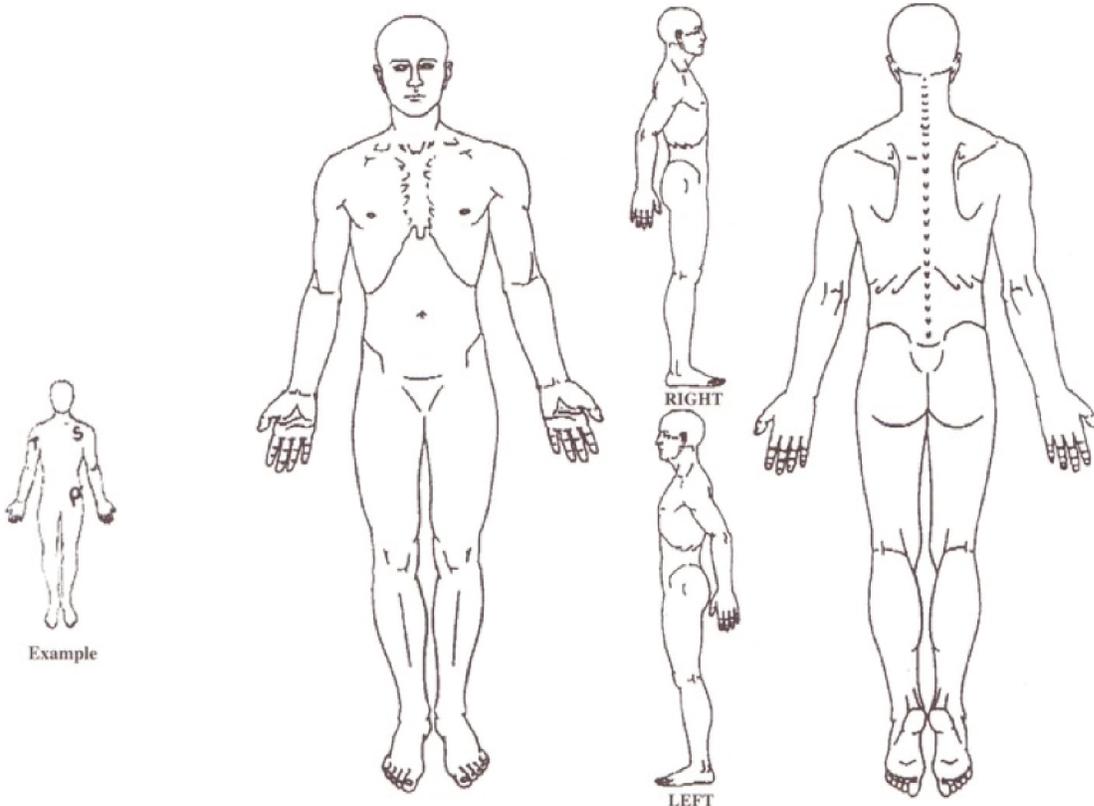
Any Change in your health, or NEW problems? Yes No

Your Current Condition and Symptoms: _____

If we have identified any other medical problems and made referrals have you followed up with specialist care? Yes No, IF YES which specialty/provider _____

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

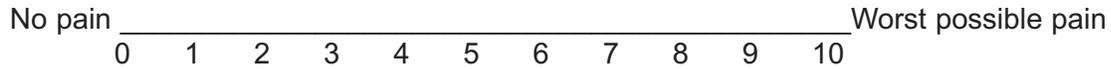


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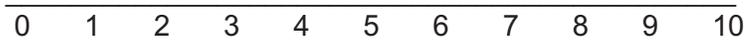
QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

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.

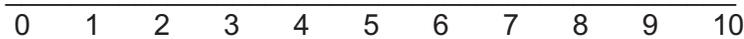
EXAMPLE:



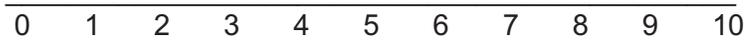
1. How would you rate your pain RIGHT NOW?



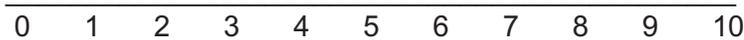
2. What is your typical or AVERAGE pain?



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?)



Medications I am CURRENTLY taking: **NO CHANGES**

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

Medication	Dosage	# Times Taken/Day	Reason for taking

Relieving or Exacerbating Factors of Pain:

Do any 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 | <input type="checkbox"/> no change |
| Bending backwards | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Sitting | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Standing | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Climbing stairs | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Exercise | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |

Patient Label

Relieving or Exacerbating Factors of Pain con't:

- | | | | |
|------------------------|---------------------------------|--------------------------------|------------------------------------|
| Reaching | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Coughing or straining | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Bowel movements | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Lying down | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Pushing shopping carts | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Sexual relations | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |
| Relaxation | <input type="checkbox"/> better | <input type="checkbox"/> worse | <input type="checkbox"/> no change |

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

Patient Signature: _____ 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	Slightly	Moderately	Very Much	Extremely
<input type="checkbox"/>				
0	0	0	1	1

Total Score (all 9): _____

Sub Score (Q5-9): _____