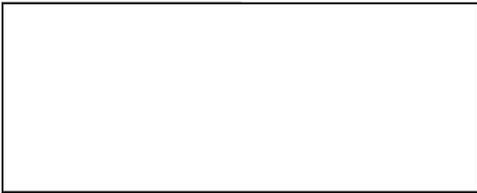




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Patient Label



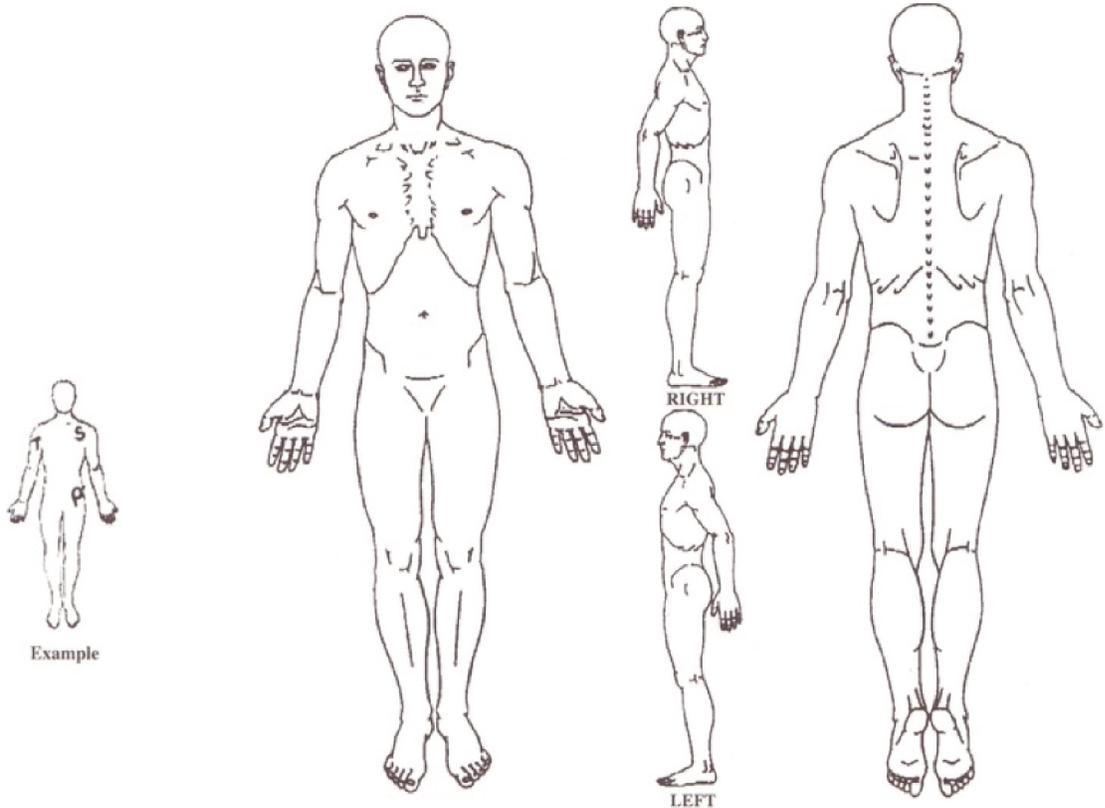
Any Change in your health, or NEW problems? Yes No

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

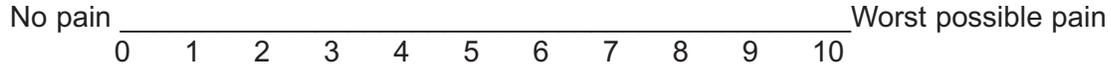


Patient Label

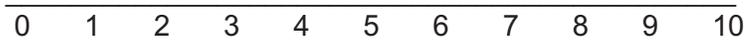
QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

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.

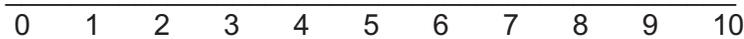
EXAMPLE:



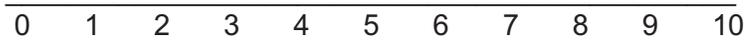
1. How would you rate your pain RIGHT NOW?



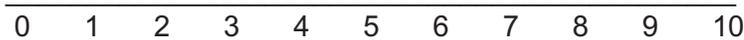
2. What is your typical or AVERAGE pain?



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?)



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, Coughing or straining, Bowel movements, Lying down, Pushing shopping carts, Sexual relations, Relaxation. Each item has checkboxes for better, worse, and 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:



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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 _____ / _____