RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

NB-ISAEC

New Brunswick Inter-professional Spine Assessment and Education Clinic

PATIENT INTAKE

Patient Information			
Name:			Medicare#:
❑ Female ❑ Male	Age:	Date of Birth: dd/mm/yy	Phone: ( )
Address:		City:	
Email:		Postal Code:	

Back Specific History

Where has the pain been the worst? (mark one) ❑ Back ❑ Leg ❑ Equal

Does the pain stop completely, even for a moment? ❑ No ❑ Yes

How did your back problem start? ❑ Injury ❑ Accident ❑ No specific cause

Is there a previous history of back problems? ❑ No ❑ Yes. Describe:

Have you had any surgery for your back problems? ❑ No ❑ Yes. Please describe:

How long have you had your current episode of low back related symptoms?

❑ <6 weeks ❑ 6 – 12 weeks ❑ 3 – 6 months ❑ 6 – 12 months ❑ > 12 months ❑ Not Applicable

As a result of your back problem, have you been, or are you currently involved with: (mark all that apply)

❑ Legal Action ❑ Insurance Claim ❑ Workers Compensation ❑ No Claim

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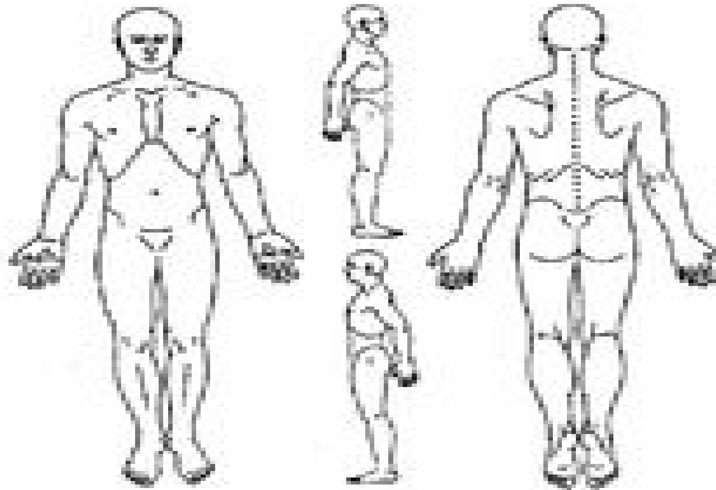
Pain Diagram

Please mark the area of injury or discomfort on the chart below



Back/Leg Pain

a. Indicate on the line below where you average pain level in your **back** is, ranging from no pain to the worst possible pain you can imagine.

BACK PAIN at it's BEST (please circle to which you are referring)

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

BACK PAIN at it's WORST (please circle to which you are referring)

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

b. Indicate on the line below where your average pain level in your **leg(s)** is, ranging from no pain to the worst possible pain you can imagine.

LEG PAIN at it's BEST (please circle to which you are referring)

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

LEG PAIN at it's WORST (please circle to which you are referring)

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

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During the **past week**, how bothersome have these symptoms **been**?

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back and/or buttock pain	❑	❑	❑	❑	❑	❑
Leg pain	❑	❑	❑	❑	❑	❑
Numbness or tingling in leg and/or foot	❑	❑	❑	❑	❑	❑
Weakness in the leg and/or foot	❑	❑	❑	❑	❑	❑

Is your pain: ❑ Improving ❑ Staying the same ❑ Getting worse

What makes your symptoms

Worse: ____________________

Better: ____________________

Have you had any changes in your bowel or bladder function since the start of your back related symptoms?

❑ No ❑ Yes. Describe: ____________________

What medication(s) do you take for your pain and how often do you take them?

Name of Drug	Dose	How many per day?	When did you start taking them?
❑ None			
❑ Tylenol or other over the counter drugs			
❑ Prescription Anti-Inflammatory			
❑ Tylenol #3 or #4			
❑ Percocet			
❑ Oxycontin or Morphine			
❑ Hydromorphone/Dilaudid			
❑ Other: ____________			

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Function

Employment Status:

What do you do for work? ____________________

Are you:

❑ Currently Working ❑ Modified Duties ❑ Student ❑ Retired
❑ Not Employed ❑ On Disability Benefits ❑ Other: ____________

Is your job:

Physically Demanding ❑ No ❑ Yes. Describe: ____________________

Mentally Demanding ❑ No ❑ Yes. Describe: ____________________

How often do you exercise? (e.g. 20 minutes or more of nonstop activity)

❑ Never, due to low back pain ❑ Never ❑ Once or less per week ❑ Twice or more per week

What recreational activities have you had to give up because of your pain?

	Please check a unit of time or distance
How long can you SIT comfortably for?	☐☐☐ ❑ minutes
How long can you STAND comfortably for?	☐☐☐ ❑ minutes
How long can you WALK comfortably for?	☐☐☐ ❑ minutes
How long can you SLEEP comfortably for?	☐☐☐ hours

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Have you tried any treatments for your pain? Mark which apply		
	Helpful	**No Benefit**
❑ Chiropractic	❑	❑
❑ Physiotherapy	❑	❑
❑ Massage	❑	❑
❑ Acupuncture	❑	❑
❑ Other	❑	❑

Have you had any investigations for your back problem? ❑ No ❑ Yes. See below

Type of Investigation:	❑ X-ray	❑ CT Scan	❑ MRI	❑ Bone Scan	❑ EMG/Nerve Conduction
Date of Investigation:					

Past Medical History

Please indicate if you are currently or have been previously treated for the following conditions:	Do you have the problem?	Does it limit your function?
High Cholesterol	❑ No ❑ Yes	❑ No ❑ Yes
High Blood Pressure	❑ No ❑ Yes	❑ No ❑ Yes
Stroke	❑ No ❑ Yes	❑ No ❑ Yes
Coronary Artery Disease	❑ No ❑ Yes	❑ No ❑ Yes
Asthma/ Chronic Obstructive Pulmonary Disease	❑ No ❑ Yes	❑ No ❑ Yes
Peripheral Vascular Disease	❑ No ❑ Yes	❑ No ❑ Yes
Diabetes	❑ No ❑ Yes	❑ No ❑ Yes
Kidney Disease	❑ No ❑ Yes	❑ No ❑ Yes
Liver Disease	❑ No ❑ Yes	❑ No ❑ Yes
Ulcer or Stomach Disease	❑ No ❑ Yes	❑ No ❑ Yes
Anaemia or Other Blood Disease	❑ No ❑ Yes	❑ No ❑ Yes
Cancer	❑ No ❑ Yes	❑ No ❑ Yes
Depression	❑ No ❑ Yes	❑ No ❑ Yes
Anxiety, Bipolar Disorder, Obsessive Compulsive Disorder and Panic Disorder	❑ No ❑ Yes	❑ No ❑ Yes
Osteoarthritis	❑ No ❑ Yes	❑ No ❑ Yes
Rheumatoid Arthritis	❑ No ❑ Yes	❑ No ❑ Yes
Inflammatory Bowel Disease (ie. Chron's/Colitis)	❑ No ❑ Yes	❑ No ❑ Yes
Psoriasis	❑ No ❑ Yes	❑ No ❑ Yes
Other Medical Problems (please specify):	❑ No ❑ Yes	❑ No ❑ Yes
	❑ No ❑ Yes	❑ No ❑ Yes

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Please list any medications (other than your pain medications) that you are currently taking (if any):

Please list any surgical procedures you have had to date:

Do you have any allergies?

❑ No ❑ Yes. Describe: ____________________

Do you smoke?

❑ No ❑ Yes. How much? ____________________ Quit. When? ____________________

What results do you expect from your participation in this program (ISAEC) (mark one response on each line)

	Not at all likely	Slightly likely	Somewhat likely	Very likely	Extremely likely	Not applicable
Relief from symptoms	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
To do more everyday household or yard activities	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
To sleep more comfortably	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
To go back to my usual job	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
To exercise and do recreational activities	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6
To prevent future disability	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6

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PATIENT INTAKE

Oswestry Disability Index (ODI)

DIRECTIONS: Answer every question by marking the correct box. If you need to change an answer, completely scratch out the incorrect answer and mark the correct box. If you are unsure about how to answer a question, please give the best answer you can. Mark only one answer for each question unless instructed otherwise.

1. PAIN INTENSITY:

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

2. PERSONAL CARE (WASHING, DRESSING, ETC.):

- ❑ I can look after myself normally without it causing extra pain.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help everyday in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty and stay in bed.

3. LIFTING:

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. 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 very light weights.
- ❑ I cannot lift or carry anything at all.

4. WALKING:

- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than 1 mile.
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

5. SITTING:

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favourite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than thirty minutes.
- ❑ Pain prevents me from sitting more than ten minutes.
- ❑ Pain prevents me from sitting at all.

6. STANDING:

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives extra pain.
- ❑ Pain prevents me from standing more than one hour.
- ❑ Pain prevents me from standing more than thirty minutes.
- ❑ Pain prevents me from standing more than ten minutes.
- ❑ Pain prevents me from standing at all.

7. SLEEPING:

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain I have less than 4 hours sleep.
- ❑ Because of pain I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

8. SEX LIFE (if applicable):

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

9. SOCIAL LIFE:

- ❑ My social life is normal and gives me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ❑ Pain has more restricted my social life and I do not go out as often.
- ❑ Pain has restricted my social life to home.
- ❑ I have no social life because of pain.

10. TRAVELING:

- ❑ I can travel anywhere without extra pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys over two hours.
- ❑ Pain restricts me to journeys less than one hour.
- ❑ Pain restricts me to short journeys under thirty minutes.
- ❑ Pain prevents me from traveling except to the doctor or hospital.

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Start Back

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1. My back pain has **spread down my leg(s)** at some time in the last 2 weeks	❑	❑
2. I have had pain in the **shoulder** or **neck** at some time 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 pain is terrible** and **it's never going to get any better**	❑	❑
8. In general, I have **not enjoyed** all the things 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

Name: ______________________ Signature: ______________________

Date: ______________________