RAPID ACCESS CLINIC
LOW BACK PAIN

Ontario

PATIENT INTAKE Date: dd/mm/yy

Patient Information			
Name:			OHIP#:
☐Male ☐Female	Age:	Date of Birth: dd/mm/yy	Phone:
Address:			City:
Email:			Postal Code:

Back Specific History

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

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

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	☐	☐	☐	☐	☐	☐
Weakness in the leg and/or foot	☐	☐	☐	☐	☐	☐

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 ☐ N/A

Is your pain: ☐ Improving ☐ Staying the same ☐ Worsening

Have you had back problems before your current episode of back symptoms? ☐ Yes ☐ No

What makes your symptoms better? (mark all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Heat/Cold ☐ Bending Forwards
☐ Medication ☐ Rest ☐ Activity ☐ Stretching ☐ Exercise ☐ Bending Backwards
☐ Sessions with a physio/chiro etc. ☐ Other. Please specify _____

What makes your symptoms worse? (mark all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending Forwards ☐ Bending Sideways
☐ Lifting ☐ Inactivity ☐ Coughing ☐ Sneezing ☐ Bending Backwards
☐ Other. Please specify: _____

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

☐No ☐Yes. Describe: _____

Because 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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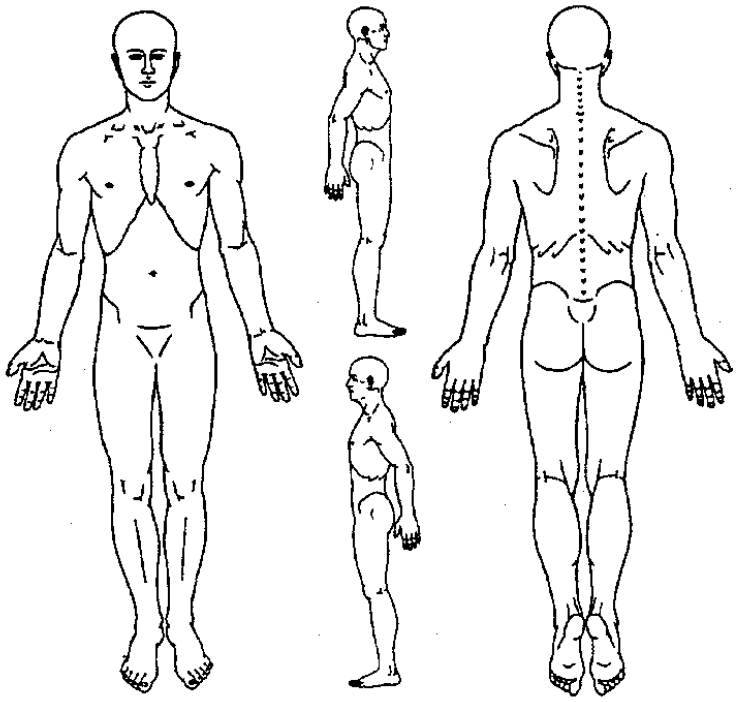
Pain Diagram - Please mark the area of injury or discomfort on the chart below



Indicate below how you would rate your average pain level during the past week in your back and leg(s) (as applicable), ranging from **'No pain'** to **'Worst possible pain you can imagine'.**

Back pain <u>at its best</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain *Worst possible pain*

Back pain <u>at its worst</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain *Worst possible pain*

Leg pain <u>at its best</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain *Worst possible pain*

Leg pain <u>at its worst</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain *Worst possible pain*

How long can you comfortably?

Activity:	**Sit**	**Stand**	**Walk**	**Sleep**
Time:	_____ mins	_____ mins	_____ mins	_____ hrs

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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: _____			

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

_____

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

	☐ X-ray	☐ CT Scan	☐ MRI	☐ Bone scan	☐ EMG
Date of Investigation:					

Have you tried any treatments for your pain? Mark which apply

Treatment	Helpful	No Benefit
☐ Chiropractic	☐	☐
☐ Physiotherapy	☐	☐
☐ Massage	☐	☐
☐ Acupuncture	☐	☐
☐ Other	☐	☐

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

Employment Status:

☐ Currently Working ☐ Modified Duties ☐ Student ☐ Other: _____
☐ Not Employed ☐ On Disability Benefits ☐ Retired

If employed, what do you do for work? _____

Does the nature of your work involve? (Mark all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Carrying ☐ Bending ☐ Twisting
☐ Driving ☐ Other. Please specify: _____

I have support from people who can assist me with activities in the home, work or community? (check one)

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

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Medical History. Please indicate if you are currently being treated for any of the following conditions:

Conditions (mark all that apply)	Does it limit your function?	Conditions (mark all that apply)	Does it limit your function?
☐ High Cholesterol	☐No ☐Yes	☐ Diabetes	☐No ☐Yes
☐ High Blood Pressure	☐No ☐Yes	☐ Kidney Disease	☐No ☐Yes
☐ Stroke	☐No ☐Yes	☐ Liver Disease	☐No ☐Yes
☐ Heart Attack/Coronary Artery Disease	☐No ☐Yes	☐ Ulcer or Stomach Disease	☐No ☐Yes
☐ Heart Failure	☐No ☐Yes	☐ Thyroid Disease	☐No ☐Yes
☐ Lung Disease (e.g. asthma, COPD)	☐No ☐Yes	☐ Depression	☐No ☐Yes
☐ Anaemia or Other Blood Disease	☐No ☐Yes	☐ Anxiety	☐No ☐Yes
☐ Cancer	☐No ☐Yes	☐ Chronic Neck Pain	☐No ☐Yes
☐ Dementia	☐No ☐Yes	☐ Migraine Headaches	☐No ☐Yes
☐ Osteoarthritis/Degenerative Arthritis	☐No ☐Yes	☐ Chronic Pelvic Pain	☐No ☐Yes
☐ Rheumatoid Arthritis	☐No ☐Yes	☐ Fibromyalgia	☐No ☐Yes

☐ Other Medical Problems (please specify): _____	☐No ☐Yes

Please list *current prescribed* medications:

_____

_____

Please list previous surgeries: _____

_____

Do you have any drug allergies? ☐No ☐Yes. Describe _____

Do you smoke? ☐ No ☐Yes. How much? _____ ☐Quit. When? _____

What results do you hope to achieve from your visit today? (Mark one response on each line)

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

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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 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 every day 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 lift only 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 walking more than 1 mile.
- ☐ Pain prevents me walking more than 1/2 mile.
- ☐ Pain prevents me walking more than 1/4 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 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 an hour.
- ☐ Pain prevents me from sitting more than 10 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 1 hour.
- ☐ Pain prevents me from standing more than 1/2 an hour.
- ☐ Pain prevents me from standing more than 10 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 causes 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 (e.g., dancing, sports)
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain

10. TRAVELLING:
- ☐ I can travel anywhere without 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 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment

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EQ-5D

Under each heading, please tick the **ONE** box that best describes your health **TODAY:**

MOBILITY:

☐ I have no problems walking about
☐ I have slight problems in walking about
☐ I have moderate problems in walking about
☐ I have severe problems in walking about
☐ I am unable to walk about

SELF-CARE:

☐ I have no problems washing or dressing myself
☐ I have slight problems washing or dressing myself
☐ I have moderate problems washing or dressing myself
☐ I have severe problems washing or dressing myself
☐ I am unable to wash or dress myself

USUAL ACTIVITIES (eg., work, study, housework, family or leisure activities):

☐ I have no problems doing my usual activities
☐ I have slight problems doing my usual activities
☐ I have moderate problems doing my usual activities
☐ I have severe problems doing my usual activities
☐ I am unable to do my usual activities

PAIN/DISCOMFORT:

☐ I have no pain or discomfort
☐ I have slight pain or discomfort
☐ I have moderate pain or discomfort
☐ I have severe pain or discomfort
☐ I have extreme pain or discomfort

ANXIETY/DEPRESSION:

☐ I am not anxious or depressed
☐ I am slightly anxious or depressed
☐ I am moderately anxious or depressed
☐ i am severely anxious or depressed
☐ I am extremely anxious or depressed

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

Total score (all 9): _____ Sub Score (Q5-9):_____