Patient INTAKE Survey
Lower Back

Staff Only

Patient Identification Number	Survey Date MM DD YYYY	Payer Source
Please select Patient Proxy, If applicable Spouse ☐ Other Family ☐ Caregiver ☐ Other ☐		**Primary Clinician**
Care Type	**Body Part** **Multiple Sites** ☐	**Impairment Category** **Multiple Categories** ☐
Patient Name (Last Name, First Name)	**Date of Birth** MM DD YYYY	**Sex** **Male** **Female**

We are interested in knowing whether you are having any difficulty with the activities listed below because of the lower back problem for which you are currently seeking attention. Please provide an answer for each activity. If you do not perform an activity, you may select Not Applicable (N/A).

Today, how much do the problems for which you are seeking attention limit:	Unable to Perform Activity	Extreme Difficulty	Quite a Bit of Difficulty	Moderate Difficulty	A little Bit of Difficulty	No Difficulty	N/A
1. Any of your usual work, housework, or school activities							
2. Your usual hobbies, recreational, or sporting activities							
3. Performing heavy activities around your home							
4. Bending or stooping							
5. Putting on your shoes or socks (pantyhose)							
6. Lifting a bag of groceries from the floor							
7. Standing for 1 hour							
8. Going up or down 2 flights of stairs (about 20 stairs)							
9. Sitting for 1 hour							
10. Driving for 1 hour							

Adapted from Stratford PW, Brinkley JM, Riddle DL. Development and initial validation of the back pain functional scale. "Spine". 2000;25(16):2095-2102.

11. Please indicate the amount of pain you have had in the last 24 hours (Please circle Number):

No Pain ——— **0 1 2 3 4 5 6 7 8 9 10** ——— **Pain as bad as it can be**

12. Indicate the number of surgeries for your primary condition ____0 ____1 ____2 +

13. How many days ago did this condition begin?

_____0 - 7 _____8 - 14 _____15 - 21 _____22 - 90 _____91 - 6 mo. _____More than 6 mo.

14. Are you taking prescription medication for this condition? _____ Yes _____ No

15. Have you received treatments for this condition before? _____ Yes _____ No

16. I should not do physical activities which (might) make my pain worse.

___0 - Completely disagree ___1 ___2 ___3 - Unsure ___4 ___5 ___6 - Completely agree

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17. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?

_____ **At least 3 times per week** _____ **Once or twice a week** _____ **Seldom or never**

18. What is your present employment status? (Mark ONE response only)

_____ Employed and presently working full duty at same job
_____ Employed and presently working full duty at different job
_____ Employed and presently working restricted duty at same job
_____ Employed and presently working restricted duty at different job
_____ Employed but presently not working due to my condition
_____ Previously employed and receiving disability benefits for my condition
_____ Unemployed
_____ Retired
_____ Student
_____ Other

19. Other health problems may affect your treatment. Please check any of the following problems that apply to you:

_____ Arthritis (rheumatoid / osteoarthritis)
_____ Osteoporosis
_____ Asthma
_____ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema
_____ Angina
_____ Congestive Heart Failure (or heart disease)
_____ Heart Attack (Myocardial Infarction)
_____ High Blood Pressure
_____ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
_____ Stroke or TIA
_____ Peripheral Vascular Disease
_____ Headaches
_____ Diabetes Types I and II
_____ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)

_____ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
_____ Hearing Impairment (very hard of hearing, even with hearing aids)
_____ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
_____ Kidney, Bladder, Prostate or Urination Problems
_____ Previous Accidents
_____ Allergies
_____ Incontinence
_____ Anxiety or Panic Disorders
_____ Depression
_____ Other disorders
_____ Hepatitis / AIDS
_____ Prior Surgery
_____ Prosthesis / Implants
_____ Sleep dysfunction
_____ Cancer

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