

Patient INTAKE Survey Lower Back

Staff Only

Patient Identification Number	Survey Date	MM	DD	YYYY	Payer Source
Please select Patient Proxy, if applicable Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Caregiver <input type="checkbox"/> Other <input type="checkbox"/>					Primary Clinician
Care Type	Body Part	Multiple Sites <input type="checkbox"/>		Impairment Category	Multiple Categories <input type="checkbox"/>
Patient Name (Last Name, First Name)	Date of Birth			Sex	
	MM	DD	YYYY	Male <input type="checkbox"/>	Female <input type="checkbox"/>

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, because of your back problem, do you or would you have any difficulty at all ...	Unable to Perform Activity	Extreme Difficulty	Quite a Bit of Difficulty	Moderate Difficulty	A little Bit of Difficulty	No Difficulty
1. Performing any of your usual work, housework, or school activities?						
2. Performing your usual hobbies, recreational or sporting activities?						
3. Performing heavy activities around your home?						
4. Bending or stooping?						
5. Lifting a box of groceries from the floor?						
Does or would your back problem limit:				Yes, limited a lot	Yes, limited a little	No, not limited at all
6. Vigorous activities like running, lifting heavy objects, participating in strenuous sports?						
7. Moderate activities like moving a table, pushing a vacuum cleaner, bowling, or playing golf?						
8. Lifting or carrying items like groceries?						
9. Attending social events?						
10. Getting in and out of a chair?						

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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	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center; font-size: small;">MM</td> <td style="text-align: center; font-size: small;">DD</td> <td style="text-align: center; font-size: small;">YYYY</td> </tr> <tr> <td style="border: 1px solid black; width: 40px; height: 20px;"></td> <td style="border: 1px solid black; width: 40px; height: 20px;"></td> <td style="border: 1px solid black; width: 60px; height: 20px;"></td> </tr> </table>	MM	DD	YYYY			
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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:

<ul style="list-style-type: none"> <input type="checkbox"/> Arthritis (rheumatoid / osteoarthritis) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema <input type="checkbox"/> Angina <input type="checkbox"/> Congestive Heart Failure (or heart disease) <input type="checkbox"/> Heart Attack (Myocardial Infarction) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Neurological Disease (such as Multiple Sclerosis or Parkinson's) <input type="checkbox"/> Stroke or TIA <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Headaches <input type="checkbox"/> Diabetes Types I and II <input type="checkbox"/> Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) 	<ul style="list-style-type: none"> <input type="checkbox"/> Visual Impairment (such as cataracts, glaucoma, macular degeneration) <input type="checkbox"/> Hearing Impairment (very hard of hearing, even with hearing aids) <input type="checkbox"/> Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis) <input type="checkbox"/> Kidney, Bladder, Prostate or Urination Problems <input type="checkbox"/> Previous Accidents <input type="checkbox"/> Allergies <input type="checkbox"/> Incontinence <input type="checkbox"/> Anxiety or Panic Disorders <input type="checkbox"/> Depression <input type="checkbox"/> Other disorders <input type="checkbox"/> Hepatitis / AIDS <input type="checkbox"/> Prior Surgery <input type="checkbox"/> Prosthesis / Implants <input type="checkbox"/> Sleep dysfunction <input type="checkbox"/> Cancer
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20. Height: _____ ft _____ in.

21. Weight: _____ lbs