Initial Patient Assessment for back or neck pain

1 Patient information

____ /____/____ Today's Date (M/D/Y)

First name _____ Last name _____

___-___-___ Phone number (A nurse may call to follow up)
☐ Day
☐ Evening

Doctor you see today _____

How did you first hear of us?
- ☐ Friend/relative/word-of-mouth
- ☐ Newspaper/magazine
- ☐ Internet/web site
- ☐ Health insurance directory
- ☐ Yellow Pages/phone book
- ☐ Dr: _____

Your age:
- ☐ <18
- ☐ 18-64
- ☐ 65+

Sex:
- ☐ Male
- ☐ Female

2 Your symptoms

Which of the following do you have? (Check all that apply)
- ☐ Back pain ☐ Neck pain
- ☐ Tingling in arm or leg ☐ Weakness in arm or leg

How long have you suffered from these symptoms?
- ☐ ≤ 6 weeks ☐ 7 to 12 weeks ☐ 4 months or more

Do you have pain radiating PAST your knee or elbow?
- ☐ Yes ☐ No

Does your leg or arm ever go numb?
- ☐ Yes ☐ No

Have you had back or neck surgery before?
- ☐ Yes ☐ No

Does your back or neck pain wake you up at night?
- ☐ Yes ☐ No

How many pills do you take each day for pain relief?
- ☐ No pills ☐ 1 to 4 pills ☐ 5 or more pills daily

Circle your pain level on a scale of 1 to 10, with 1 being no pain at all, and 10 being extreme pain.

1 2 3 4 5 6 7 8 9 10
no pain extreme pain

3 Your expectations

What result do you expect from your care?

Relief from pain symptoms	☐ Yes	☐ No	☐ Doesn't apply
Return to your job	☐ Yes	☐ No	☐ Doesn't apply
Return to leisure activities	☐ Yes	☐ No	☐ Doesn't apply
Improved sleep	☐ Yes	☐ No	☐ Doesn't apply

4 How do symptoms affect your life?

Which of the following describes you currently?
- ☐ Working
- ☐ Not working because of back or neck problem
- ☐ Not working because of another health problem
- ☐ Homemaker, retired or unemployed

Did your back or neck injury happen at work? ☐ Yes ☐ No

If you are not working, how long have you been off work because of your back or neck problem?
- ☐ Less than 1 month ☐ Longer than 1 month

Describe the activities involved in your job that you have now, or hope to return to: (Check all that apply)
- ☐ Heavy/frequent lifting ☐ Prolonged sitting or driving
- ☐ Pushing/pulling ☐ Prolonged standing

The following are activities you might do in a typical day. Does your back or neck pain limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	Not limited at all
Strenuous activities... like running, lifting heavy objects	☐ 1	☐ 2	☐ 3
Moderate activities... like housework, pushing a vacuum, playing golf	☐ 1	☐ 2	☐ 3
Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
Climbing several flights of stairs	☐ 1	☐ 2	☐ 3
Walking for 30 minutes	☐ 1	☐ 2	☐ 3
Sitting for 30 minutes	☐ 1	☐ 2	☐ 3
Standing for 30 minutes	☐ 1	☐ 2	☐ 3
Getting dressed, bathing	☐ 1	☐ 2	☐ 3

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