

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



Patient INTAKE Survey - Lower Back

Patient Identification Number	Survey Date						
	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 2px 5px;">MM</td> <td style="text-align: center; padding: 2px 5px;">DD</td> <td style="text-align: center; padding: 2px 5px;">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			
MM	DD	YYYY					

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"> _____ 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) 	<ul style="list-style-type: none"> _____ 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
---	--

20. Height: _____ ft _____ in.

21. Weight: _____ lbs