

## Back/Neck Pain Consult Form

**Pt Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_  
**Sex:** F / M **ODI:** \_\_\_\_% **MR#:** \_\_\_\_\_  
**Referring physician** \_\_\_\_\_ **PCP** \_\_\_\_\_

How long have you had the pain/ when did it start worsening? \_\_\_\_\_/\_\_\_\_\_

What caused the pain or how did it happen? \_\_\_\_\_

Where do you have the pain at? Does it radiate to your another body parts and where?  
\_\_\_\_\_

Intensity—How bad is your pain of a scale 0—10? (Please circle one) 0 = no pain / 10 worse pain  
0 1 2 3 4 5 6 7 8 9 10

Dull achy Yes / No \_\_\_\_\_ where Sharp pain Yes / No \_\_\_\_\_ where

Shooting pain Yes / No \_\_\_\_\_ **Weakness** Yes / No \_\_\_\_\_

Tenderness Yes / No \_\_\_\_\_ Numbness Yes / No \_\_\_\_\_

Stabbing Yes / No \_\_\_\_\_ Tingling Yes / No \_\_\_\_\_

Burning \_\_\_\_/10 Yes / No \_\_\_\_\_

Is the pain constant or does it come and goes? \_\_\_\_\_

If intermittent, how many times does it occur in one day? \_\_\_\_\_

And how long does it last for? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_ What makes the pain worse? \_\_\_\_\_

**Bladder incontinence?** Yes / No Did it happen after the back pain? Yes / No

**Bowel incontinence?** Yes / No Did it happen after the back pain? Yes / No

Do you have trouble bending twisting, or crossing your legs? Yes / No \_\_\_\_\_

Do you have trouble walking / standing / sitting? With / without pain med? Yes / No \_\_\_\_\_

How long can you walk / stand / sit with pain killer and without? \_\_\_\_\_

Have you had previous fractures, back surgeries or back injections? Yes / No

If yes, where and which doctor did it? \_\_\_\_\_

Have you been to physical therapy / chiropractor for your back pain? Yes / No

If yes, where? \_\_\_\_\_ For how long? \_\_\_\_\_

Office use only:

Signature: \_\_\_\_\_

DOS: \_\_\_\_/\_\_\_\_/2009



MedRec#: \_\_\_\_\_

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and mark in each section the ONE box that *most closely* describes your present day situation.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

### Section 1 – Pain Intensity:

- A. My pain is mild to moderate. I do not need pain killers.
- B. The pain is bad, but I manage without taking pain killers.
- C. Pain killers give complete relief from pain.
- D. Pain killers give moderate relief from pain.
- E. Pain killers give very little relief from pain.
- F. Pain killers have no effect on the pain.

### Section 2 – Personal Care:

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed; I wash with difficulty and stay in bed.

### Section 3 – Lifting:

- A. I can lift heavy weights without causing extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the *floor* but I can manage if they are conveniently positioned, for example, on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

### Section 4 – Walking:

- A. I can walk as far as I wish.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk if I use a cane or crutches.
- F. I am in bed or in a chair for most of every day.

### Section 5 – Sitting:

- A. I can sit in any chair for as long as I like.
- B. I can sit in my favorite chair only, for as long as I like.
- C. Pain prevents me from sitting for more than 1 hour.
- D. Pain prevents me from sitting for more than ½ hour.
- E. Pain prevents me from sitting for more than ¼ hour.
- F. Pain prevents me from sitting at all.

### Section 6 – Standing:

- A. I can stand as long as I want without extra pain.
- B. I can stand as long as I want, but it gives me extra pain.
- C. Pain prevents me from standing for more than 1 hour.
- D. Pain prevents me from standing for more than ½ hour.
- E. Pain prevents me from standing for more than 10 minutes.
- F. Pain prevents me from standing at all.

### Section 7 – Sleeping:

- A. Pain does not prevent me from sleeping well.
- B. I sleep well but only when taking medicine.
- C. Even when I take medication, I sleep less than 6 hours.
- D. Even when I take medication, I sleep less than 4 hours.
- E. Even when I take medication, I sleep less than 2 hours.
- F. Pain prevents me from sleeping at all.

### Section 8 – Social Life:

- A. My social life is normal and causes me no extra pain.
- B. My social life is normal, but increases the degree of pain.
- C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- D. Pain has restricted my social life and I do not go out as often.
- E. Pain has restricted my social life to my home.
- F. I have no social life because of pain.

### Section 9 – Sexual Activity:

- A. My sexual activity is normal and causes no extra pain.
- B. My sexual activity is normal, but causes some extra pain.
- C. My sexual activity is nearly normal, but is very painful.
- D. My sexual activity is severely restricted by pain.
- E. My sexual activity is nearly absent because of pain.
- F. Pain prevents any sexual activity at all.

### Section 10 – Traveling:

- A. I can travel anywhere without extra pain.
- B. I can travel anywhere, but it gives me extra pain.
- C. Pain is bad, but I manage journeys over 2 hours.
- D. Pain restricts me to journeys of less than 1 hour.
- E. Pain restricts me to necessary journeys under ½ hour.
- F. Pain prevents traveling except to the doctor / hospital.

### For Office Use Only:

ODI Score: \_\_\_\_\_ / \_\_\_\_\_ %

### Pain Diagram

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please shade in the area of pain, numbness and / or tingling:

