Low Back Pain
Clinical Assessment Measures

1. Print
2. Complete Form
3. Present Completed Form at time of appointment

Dear Patient,

The Penn Spine Center is dedicated to quality clinical care and clinical research focused on improving function and quality of life for people with musculoskeletal problems. Please complete the following forms as this will enable us to understand more about how your pain is affecting your life and your function. Present these completed forms to the front desk administrative staff before your appointment. This information will be used for your clinical care, research and to improve our services. Providing this information is voluntary. You will not be denied services if you decide not to answer these questions.

To get the most from your appointment, please remember to present prior radiographic imaging studies (x-ray/MRI reports and actual pictures).

Sincerely,

University of Pennsylvania
Penn Spine Center Team
# Health Screening Questions

**Hospital of the University of Pennsylvania**

**TO BE COMPLETED BY PATIENT**

## Advanced Health Care Directive

Do you have an Advanced Directive Living Will?  
**YES / NO**

## Pain Screening

1. Do you have a problem with pain?  
   **YES / NO**

   2. If YES, where is your pain located?  
   
   3. Rate the severity of your pain:_____
   
   (0 = no pain, 10 = severe pain.)

## Nutritional Screening

Have you had an unintentional weight loss of more than 10 pounds over the past 3 months?  
**YES / NO**

## Educational/Learning Needs Screening

**I learn best by:**

- Reading
- Listening
- Pictures
- Demonstration
- Video
- Other__________

**Language used:** English  
Other________

Should we be aware of any cultural or religious beliefs that may affect your health care?  
**YES / NO**

Explain: ________________________________

## Functional Screening

1. Have you fallen more than once in the past year or hurt yourself in a fall?  
   **YES / NO**

2. Do you feel at risk of falling?  
   **YES / NO**

## Psychosocial Screening

1. During the last month have you felt down, depressed or hopeless?  
   **YES / NO**

2. Are you experiencing any abuse or violence at home or in any personal relationship?  
   **YES / NO**

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**Office Use Only**

Refer any 'yes' responses to treating provider (MD, CRNP, PA)

**Referred to:** ____________________________________________  
**Treating provider:** ______________________________________

**Reviewer Signature:** ____________________________________  
**Date:** ________  **Time:** __________

**Print Name:** ____________________________________________

UPHS-DBB-3 AEL 9/2008
Medical History Intake Form

Date of Birth: __/__/__

CC: What problem/issue brings you here today?

HPI: How and when did it start?

What makes it worse?
- walking
- sitting
- standing
- lying down
- nothing
- exercise

What makes it better?
- walking
- sitting
- standing
- lying down
- nothing
- exercise

If you had to sit or stand for one hour straight, which would you choose?
- Sit
- Stand

What do you want to accomplish from today’s visit?

Diagnosis
- Treatment Options
- X-ray Rx
- MRI Rx
- Med Rx
- Review Test
- Injection Rx

Please make a mark on the line below to indicate the level of discomfort you have today.

No Pain

<table>
<thead>
<tr>
<th>0</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<th>10</th>
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<td>Worst Pain Ever</td>
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</table>

Please describe what the pain feels like: Dull | Achy | Burning | Stabbing | Numb | Tingling | Pulling | Cramping | Stiff | Tight

Please describe the time course of your pain: Constant | Comes and goes (fluctuating) | Worsening | Improving | Staying the same

What is your Occupation?

Physical requirements:
- Prolonged Sitting
- Prolonged Standing
- Lifting
- Travel
- Driving
- Computer
- Phone
- Childcare

Employment status:
- Full-time
- Part-time
- Light Duty
- Off Duty due to injury
- Full-time Parent
- Not working
- Retired

Number of alcoholic beverages per week?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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<td></td>
<td>Number of alcoholic beverages per week</td>
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</tbody>
</table>

Tobacco use (i.e. cigarette, cigar, pipe, chew)

- Current
- Quit
- Never

Medications (i.e. Prescription, Over-the-Counter (i.e. Advil, Aspirin), Supplements, Vitamins)

Medical/Surgical History (i.e. Surgeries, Diabetes, Cancer, High blood pressure, Heart attack, Pacemaker, Arthritis, Fractures, Accidents, Osteoporosis)

Family History (Cancer, Heart disease, Stroke, Arthritis, Osteoporosis)

Allergies to medicines (penicillin, contrast, iodine):

Please draw where you have pain

Right
Left
Left
Right

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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What are you doing for exercise now?

- Fevers, unintentional weight change?
- Vision change, double vision?
- Difficulty swallowing, headaches?
- Chest pain, palpitations?
- Shortness of breath, wheezing, cough after exercise?
- Nausea, vomiting, black stools, loss of control of stools?
- Loss of control of urine, urinary frequency or urgency?
- New rashes or psoriasis or skin lesions?
- Dizziness, weakness, numbness, tingling?
- Depressed mood, sleep problems, anxiety?
- Current low back pain, other joint swelling or muscle pain?
- Are you pregnant, trying to get pregnant or breastfeeding?
- Last menstrual period date: Periods regular?

Patient’s Signature: __________________________

Physician Initials/Date/Time: __/__/__
Pain Disability Index

Patient Name: ____________________  MRN: ____________________  Date: ______/_____/______

In order to determine how effective your treatment is, we need to know how much pain is interfering in your normal activities. Please select the number on the scale which describes the level of disability you have experienced in each area OVER THE PAST WEEK.

A score of "0" means no disability at all, and a score of "10" indicates that all of the activities which you would normally do have been totally disrupted or prevented by your pain over the past week. Circle "0" if a category does not apply.

**FAMILY/HOME RESPONSIBILITIES:** This category refers to activities related to the home or family. It includes chores or duties performed around the house (e.g., yard work, house cleaning) and errands or favors for other family members (e.g., driving the children to school).

<table>
<thead>
<tr>
<th>No Disability</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Total Disability</th>
</tr>
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**RECREATION:** This category includes hobbies, sports, and other similar leisure time activities.

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**SOCIAL ACTIVITY:** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

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**OCCUPATION:** This category refers to activities that are a part of or directly related to one’s job. This includes non-paying jobs as well, such as housewife or volunteer worker.

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**SEXUAL BEHAVIOR:** This category refers to the frequency and quality of one’s sex life.

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**SELF-CARE:** This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed).

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**LIFE-SUPPORT ACTIVITY:** This category refers to basic life-supporting behaviors such as eating and sleeping.

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**Patient Specific Functional Scale**

Identify the most important activity that you are unable to do or are having difficulty with as a result of your current problem. Today, what activity are you unable to do or having difficulty with because of your current problem? ______________

(examples may include things like, “sitting for 1 hour”, “standing for 1 hour”, “picking up my child”, “running for 30 minutes”, “walking for 1 block”).

*Please rate your ability to perform this functional activity now:

<table>
<thead>
<tr>
<th>Unable to perform</th>
<th>Able to perform at prior level</th>
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<tr>
<td>0</td>
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* Note that this scale is rated on your ABILITY to do the activity – so it is reverse from the questions above.
Oswestry Disability Index
Low Back

Patient Name: ____________________  MRN: ____________________  Date of Birth: ___/____/______
Date: _____/____/____

INSTRUCTIONS: Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in every day life. Please answer every section. Mark one box only in each section that most closely describes you today.

Pain Intensity
□ I have no pain at the moment
□ The pain is very mild at the moment
□ The pain is moderate at the moment
□ The pain is fairly severe at the moment
□ The pain is very severe at the moment
□ The pain is the worst imaginable at the moment

Personal Care
□ I can look after myself normally without causing extra pain
□ I can look after myself normally but it causes extra pain
□ It is painful to look after myself and I am slow and careful
□ I need some help but can manage most of my personal care
□ I need help every day in most aspects of self care
□ I do not get dressed, I wash with difficulty and stay in bed

Lifting
□ I can lift heavy weights without extra pain
□ I can lift heavy weights but it gives me extra pain
□ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
□ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
□ I can only lift very light weights
□ I cannot lift or carry anything

Walking
□ Pain does not prevent me from walking any distance
□ Pain prevents me from walking more than 1 mile
□ Pain prevents me from walking more than ½ of a mile
□ Pain prevents me from walking more than 100 yards
□ I can only walk using a stick or crutches
□ I am in bed most of the time

Sitting
□ I can sit in any chair for as long as I like
□ I can sit in my favorite chair for as long as I like
□ Pain prevents me from sitting more than 1 hour
□ Pain prevents me from sitting more than ½ an hour
□ Pain prevents me from sitting more than 10 minutes
□ Pain prevents me from sitting at all
Patient Name: ____________________  MRN: ____________________
Date of Birth: ___/____/____

Date:____/____/____

Standing
☐ I can stand as long as I want without extra pain
☐ I can stand as long as I want but it gives me extra pain
☐ Pain prevents me from standing for more than 1 hour
☐ Pain prevents me from standing for more than ½ an hour
☐ Pain prevents me from standing for more than 10 minutes
☐ Pain prevents me from standing at all

Sleeping
☐ My sleep is never disturbed by pain
☐ My sleep is occasionally disturbed by pain
☐ Because of pain, I have less than 6 hours of sleep
☐ Because of pain, I have less than 4 hours of sleep
☐ Because of pain, I have less than 2 hours of sleep
☐ Pain prevents me from sleeping at all

Social Life
☐ My social life is normal and causes me no extra pain
☐ My social life is normal but increases the degree of pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg sports, etc.
☐ Pain has restricted my social life and I do not go out as often
☐ Pain has restricted social life to my home
☐ I have no social life because of pain

Traveling
☐ I can travel anywhere without pain
☐ I can travel anywhere, but it gives extra pain
☐ Pain is bad, but I manage journeys over two hours
☐ Pain restricts me to journeys less than one hour
☐ Pain restricts me to short necessary journeys less than 30 minutes
☐ Pain prevents me from traveling except to receive treatment

Employment/Homemaking
☐ My normal homemaking/job activities do not cause pain
☐ My normal homemaking/job activities increase my pain
☐ I can perform most of my homemaking/job activities, but pain prevents me from performing more physically stressful activities (eg lifting, vacuuming)
☐ Pain prevents me from doing anything but light duties
☐ Pain prevents me from doing even light duties
☐ Pain prevents me from performing any job or homemaking chores