Baseline Examination (Hand to patient.)

Demographic Information

Thank you for completing this questionnaire. This questionnaire will help us to better understand your general health and any problems related to bone and muscle conditions. Your responses will be held in the strictest confidence. Please answer every question. Some questions may look like the others, but each one is different. There is no right or wrong answer. If you are not sure how to answer a question, just give the best answer you can.

Subject ID: ____________________________ **Today's Date:** _____/_____/_____ (mm/dd/yy)

Date of Birth: _____/_____/_____ (mm/dd/yy) **Height:** __________ **Weight:** ___________

Gender:

- ☐ Female
- ☐ Male

Race:

- ☐ American Indian
- ☐ Asian
- ☐ Pacific Islander
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Hispanic
- ☐ Other _________________

Do you expect you will be able to complete all 5 sessions over a 4-week period (i.e. not going on vacation, no extended business trips scheduled, etc.)?

☐ No ☐ Yes

When did your present episode of back pain begin? (Try to be as exact as possible.) ____/____/____ (mm/dd/yy)

Question		
Do you experience weakness in your legs when you walk?	☐ Yes	☐ No
Do you have pulsating pain in your back?	☐ Yes	☐ No
Do you get pain in your legs when you walk that is relieved by resting?	☐ Yes	☐ No
Do your feet get painful during cold weather?	☐ Yes	☐ No
Do you have pain in your entire leg (front, side and back at the same time)?	☐ Yes	☐ No
Do you get pain in your tailbone?	☐ Yes	☐ No
Do you have numbness in your entire leg (front, side and back at same time)?	☐ Yes	☐ No
Does your whole leg ever give way?	☐ Yes	☐ No
Have you had any time during this episode of back pain when you have had very little pain?	☐ Yes	☐ No
Have you ever had to go to the hospital emergency room because of your pain?	☐ Yes	☐ No
Have you had any treatment for your back that has helped you?	☐ Yes	☐ No
Has all of the treatment for your back made you worse?	☐ Yes	☐ No
Do you have any numbness or tingling in your buttocks or genital area?	☐ Yes	☐ No

<u>Baseline Examination</u> (Hand to patient.)

1. Are you presently seeking treatment from any other specialists for your back pain?
   - ☐ No
   - ☐ Yes (If yes, please check all that apply below:

☐ Acupuncturist	☐ Osteopath
☐ Chiropractor	☐ Pain Clinic
☐ Emergency Room	☐ Physical Therapist
☐ General Practitioner	☐ Rheumatologist
☐ Internist	☐ Work Hardening Clinic
☐ Massage Therapist	☐ Nurse Practitioner
☐ Neurosurgeon	☐ Other:____________________________

2. Prior to your coming to physical therapy, what treatment(s) have you had for **<u>this episode</u>** of your low back pain? (Please mark all that apply.)
   - ☐ None
   - ☐ Surgery (Date and type of surgery:____)
   - ☐ Physical/Occupational Therapy
   - ☐ Medication (Date and type of medication:____)
   - ☐ Chiropractic
   - ☐ Massage Therapy
   - ☐ Splint, Brace, or Cast
   - ☐ Shoe Inserts
   - ☐ Other (Please specify:____)

Baseline Examination **(Hand to patient.)**

1. If you had to spend the rest of your life with the low back symptoms you have right now, how would you feel about it?
   - ☐ Very dissatisfied
   - ☐ Somewhat dissatisfied
   - ☐ Neutral
   - ☐ Somewhat satisfied
   - ☐ Very satisfied

2. What results do you expect from your treatment? (Check **one** response on each row.)

	Definitely yes	**Probably yes**	**Not sure**	**Probably not**	**Definitely not**	**Not applicable**
Complete relief from symptoms (pain, stiffness, swelling, numbness, weakness, instability)	☐	☐	☐	☐	☐	☐
Moderate relief from symptoms (pain, stiffness, swelling, numbness, weakness, instability)	☐	☐	☐	☐	☐	☐
To do more every day household or yard activities	☐	☐	☐	☐	☐	☐
To sleep more comfortably	☐	☐	☐	☐	☐	☐
To go back to my usual job	☐	☐	☐	☐	☐	☐
To exercise and do more recreational activities	☐	☐	☐	☐	☐	☐
To prevent future disability	☐	☐	☐	☐	☐	☐

3. During the past week, how bothersome have these symptoms been? (Check **one** response on each row that best describes your average symptoms over the past week.)

	Not at all bothersome	**Slightly bothersome**	**Somewhat bothersome**	**Moderately bothersome**	**Very bothersome**	**Extremely bothersome**
Low back and/or buttock pain	☐	☐	☐	☐	☐	☐
Leg pain	☐	☐	☐	☐	☐	☐
Numbness or tingling in leg and/or foot	☐	☐	☐	☐	☐	☐
Weakness in leg and/or foot	☐	☐	☐	☐	☐	☐

<u>Baseline Examination</u> (Hand to patient.)

1. What is your current living situation?
   - ☐ Live alone
   - ☐ Live with spouse or significant other
   - ☐ Live with other family members
   - ☐ Live with other non-family members (specify:________________________________)

2. What is your current marital status?
   - ☐ Single
   - ☐ Married
   - ☐ Living with significant other
   - ☐ Divorced/separated
   - ☐ Widowed

3. What level of education have you completed?
   - ☐ Less than high school
   - ☐ Graduated from high school
   - ☐ Some college
   - ☐ Graduated from college
   - ☐ Some post-graduate course work
   - ☐ Completed post-graduate degree

4. What is your approximate household income?
   - ☐ Less than $20,000
   - ☐ $20,000 to $35,000
   - ☐ $35,001 to $50,000
   - ☐ $50,001 to $70,000
   - ☐ Greater than $70,000

5. Do you live with someone who can take care of you? ☐ No ☐ Yes

<u>Baseline Examination</u> (Hand to patient.)

The following is a list of common health problems. In the first column please indicate if you currently or have ever had any of the problems in the past. In the second column please indicate if you are currently receiving treatment for the problem. In the last column please indicate if the problem limits any of your daily activities.

	Do you or have you had the problem?	Do you currently receive treatment for this problem?	Does this problem limit your daily activities?
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spinal Compression Fracture	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lung Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ulcer or Stomach Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Anemia or Other Blood Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Fainting	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dizziness or Vertigo	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nerve Disease or Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Muscle Disease or Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Eye Disease or Injury	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Osteoarthritis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatoid arthritis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Neck or Back Injury	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Skin Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Medical Problems (please specify) ____________ ____________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

<u>Baseline Examination</u> (Hand to patient.)

1. If you are a female, do you have any reason to believe that you may be pregnant at this time?
   - ☐ No
   - ☐ Yes
   - ☐ N/A (if you are male)

2. Please check any of the following problems that you currently experience: (check all that apply)
   - ☐ Bowel Irregularities
   - ☐ Abdominal Pain or Other Abdominal Problems
   - ☐ Rectal Bleeding
   - ☐ Bladder Irregularities
   - ☐ Menstrual Irregularities

3. Have you recently experienced a weight loss of more than 10 lbs that was not the result of dieting?
   - ☐ No
   - ☐ Yes

4. If you indicated that you have any of the above problems, are you currently under a doctor's care for the problem?
   - ☐ No
   - ☐ Yes

5. Have you had surgery within the past year?
   - ☐ No
   - ☐ Yes (Date and type of surgery:____)

6. Have you ever had surgery for your back?
   - ☐ No
   - ☐ Yes (Date and type of surgery:____)

7. Are you currently taking any medications (over the counter and/or prescribed)?
   - ☐ No
   - ☐ Yes (If yes, please list the medications that you are currently taking.)

Name of Medicine	Dose (Milligrams)	How many pills?	How many times per day?

Baseline Examination (Hand to patient.)

8. During the **past week**, how often have you taken pain medication, including narcotics or over-the-counter medications **for your low back pain**?
   - ☐ Not at all
   - ☐ Once a week
   - ☐ Once every couple of days
   - ☐ Once or twice a day
   - ☐ Three or more times a day

9. Have you smoked at least 100 cigarettes in your lifetime?
   - ☐ No
   - ☐ Yes

10. If you smoked more than 100 cigarettes in your lifetime (Proceed to the next page if you have not smoked more than 100 cigarettes in your lifetime):

    11. On average during all of the years that you have smoked, how many cigarettes did you usually smoke per day?
        - ☐ 1 - 10
        - ☐ 11 - 20
        - ☐ 21 - 40
        - ☐ More than 40

    12. Do you smoke cigarettes now?
        - ☐ No
        - ☐ Yes

    13. Except for the times that you quit, how many years all together have you smoked cigarettes?
        - ☐ 0 - 5
        - ☐ 6 - 10
        - ☐ 11 - 20
        - ☐ More than 20 years

<u>Baseline Examination</u> (Hand to patient.)

1. Which statement best describes the work you do? (If retired, answer based on everyday activities.)
   - ☐ Mostly sedentary
   - ☐ Sedentary, substantial amount of walking required
   - ☐ Moderately active; walking, some lifting, and carrying
   - ☐ Demanding physical activity, heavy lifting, and carrying

2. Describe your employment status before your most recent injury.
   - ☐ Work regular duty full time
   - ☐ Work regular duty part time
   - ☐ Work light duty or modified position full time
   - ☐ Work light duty or modified position part time
   - ☐ Temporarily unable to work due to health status
   - ☐ Permanently unable to work or retired due to health status
   - ☐ Retired (not due to health status)
   - ☐ Unemployed
   - ☐ Homemaker (not working outside the home)
   - ☐ Student (not currently working)

3. What was the title of the job you were in when you suffered your most recent injury?

____

4. How much work have you missed due to your most recent injury?
   - ☐ Have not missed work due to injury
   - ☐ Less than 1 week
   - ☐ 1 to 2 weeks
   - ☐ 2 to 3 weeks
   - ☐ 3 to 4 weeks
   - ☐ More than 4 weeks

5. Mark the statement that best represents your working status for the past 6 weeks:
   - ☐ I have not missed any work because of my low back pain.
   - ☐ I have returned to full duty work.
   - ☐ I have returned to partial duty work.
   - ☐ I have not been able to return to work because of my low back pain.
   - ☐ I have not been able to return to work for a reason other than my low back pain.

6. Do you have an attorney to represent you as a result of your current injury?
   - ☐ No
   - ☐ Yes

7. As a result of your current back injury, are you receiving or planning to apply for workman's compensation?
   - ☐ No
   - ☐ Yes

8. Are you presently engaged in litigation related to your present injury?
   - ☐ No
   - ☐ Yes

<u>Baseline Examination</u> (Hand to patient.)

Indicate by circling the comment next to the treatment that corresponds to your amount of agreement with the following statement. Substitute each treatment into the blank as you consider your response.

I believe ________________ will significantly help to improve **<u>this episode</u>** of my back pain.

Treatment					
Medication	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Rest	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Surgery	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Modalities (i.e. ultrasound, TENS, etc.)	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Massage	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Manipulation	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Traction	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Aerobic exercise (i.e. walking, stationary cycling, Stairmaster, etc.)	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Range of motion exercises (i.e. stretching)	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree
Strengthening exercises	completely disagree	somewhat disagree	neutra l	somewhat agree	completely agree