Back Pain Questionnaire

Form B1-100

rev 3/27/2003

Patient Name_____ **Date**_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity
⓪The pain comes and goes and is very mild.
①The pain is mild and does not vary much.
②The pain comes and goes and is moderate.
③The pain is moderate and does not vary much.
④The pain comes and goes and is very severe.
⑤The pain is very severe and does not vary much.

Personal Care
⓪I do not have to change my way of washing or dressing in order to avoid pain.
①I do not normally change my way of washing or dressing even though it causes some pain.
②Washing and dressing increases the pain but I manage not to change my way of doing it.
③Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④Because of the pain I am unable to do some washing and dressing without help.
⑤Because of the pain I am unable to do any washing and dressing without help.

Sleeping
⓪I get no pain in bed.
①I get pain in bed but it does not prevent me from sleeping well.
②Because of pain my normal sleep is reduced by less than 25%.
③Pain prevents me from sleeping at all.
④Because of pain my normal sleep is reduced by less than 50%.
⑤Because of pain my normal sleep is reduced by less than 75%.

Lifting
⓪I can lift heavy weights without extra pain.
①I can lift heavy weights but it causes extra pain.
②Pain prevents me from lifting heavy weights off the floor.
③I can only lift very light weights.
④Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
⑤Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.

Sitting
⓪I can sit in any chair as long as I like.
①I can only sit in my favorite chair as long as I like.
②Pain prevents me from sitting more than 1 hour.
③I avoid sitting because it increases pain immediately.
④Pain prevents me from sitting more than 1/2 hour.
⑤Pain prevents me from sitting more than 10 minutes.

Traveling
⓪I get no pain while traveling.
①I get some pain while traveling but none of my usual forms of travel make it worse.
②I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③Pain restricts all forms of travel.
④I get extra pain while traveling which causes me to seek alternate forms of travel.
⑤Pain restricts all forms of travel except that done while lying down.

Standing
⓪I can stand as long as I want without pain.
①I have some pain while standing but it does not increase with time.
②I cannot stand for longer than 1 hour without increasing pain.
③I avoid standing because it increases pain immediately.
④I cannot stand for longer than 1/2 hour without increasing pain.
⑤I cannot stand for longer than 10 minutes without increasing pain.

Social Life
⓪My social life is normal and gives me no extra pain.
①My social life is normal but increases the degree of pain.
②I have hardly any social life because of the pain.
③Pain has restricted my social life and I do not go out very often.
④Pain has restricted my social life to my home.
⑤Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).

Walking
⓪I have no pain while walking.
①I have some pain while walking but it doesn't increase with distance.
②I cannot walk more than 1 mile without increasing pain.
③I cannot walk at all without increasing pain.
④I cannot walk more than 1/2 mile without increasing pain.
⑤I cannot walk more than 1/4 mile without increasing pain.

Changing degree of pain
⓪My pain is rapidly getting better.
①My pain fluctuates but overall is definitely getting better.
②My pain seems to be getting better but improvement is slow.
③My pain is rapidly worsening.
④My pain is neither getting better or worse.
⑤My pain is gradually worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

INFORMED CONSENT FORM PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs	range of motion testing
orthopedic testing	basic neurological testing	muscle strength testing	postural analysis
ultrasound	hot/cold therapy	electrical stimulation	radiographic studies
mechanical traction	Other (please explain)_____		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or I have not read [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert doctor's name)* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____/_____/_____

Patient's Name **Patient's Signature** **Signature of Parent of Guardian (if a minor)**

Lynn Burgin D.C **Dated:** _____

Dr.'s Name **Dr.'s Signature**