ISAEC

Inter-professional Spine Assessment and Education Clinic

R Number

Ontario

Patient Intake

Date: dd/mm/yy

Patient Information			
Name:			OHIP #:
☐ Female ☐ Male	Age:	Date of Birth: dd/mm/yy	Phone:
Address:			City:
Email:			Postal Code:

What is your current marital status?

☐ Married ☐ Common-law ☐ Single (never married) ☐ Separated ☐ Divorced ☐ Widowed

What is your ethnicity?

☐ White
☐ Black
☐ Latin / Central / South American
☐ West Asian / Arab (e.g. Afghan, Iranian, Israeli, Turk, Lebanese, etc.)
☐ South Asian (e.g. Indian, Pakistani, Sri Lankan, etc.)
☐ East Asian (e.g. Chinese, Korean, Taiwanese, Japanese, etc.)
☐ Southeast Asian (e.g. Filipino, Indonesian, Thai, Vietnamese, etc.)
☐ Native / Aboriginal Peoples of North America
☐ Other (please specify):____________________________

Back Specific History

Where has the pain been the worst? (mark one) ☐ Back Dominant ☐ Leg Dominant ☐ Equal

Does the pain stop completely, even for a moment? ☐ No ☐ Yes

How did your back problem start? ☐ Injury ☐ Accident ☐ No specific cause ☐ Don't know

Is there a previous history of back problems? ☐ No ☐ Yes. Describe: ____________________________________

____

Have you had any surgery for your back problems? ☐ No ☐ Yes. Please describe:_________________________

____

How long have you had your current episode of low back pain?

☐ < 6 weeks ☐ 6 - 12 weeks ☐ 3 - 6 months ☐ 6 - 12 months ☐ > 12 months ☐ Not Applicable

How long have you had your current episode of leg pain?

☐ < 6 weeks ☐ 6 - 12 weeks ☐ 3 - 6 months ☐ 6 - 12 months ☐ > 12 months ☐ Not Applicable

As a result of your back problem, have you been, or are you currently involved with: (mark all that apply)

☐ Legal Action ☐ Insurance Claim ☐ Workers Compensation ☐ No Claim

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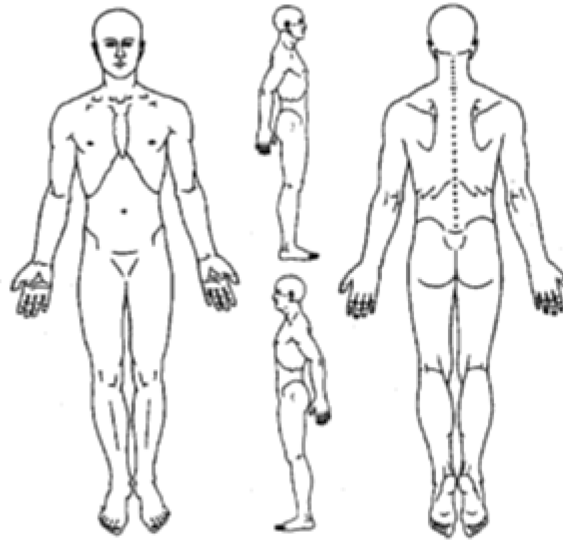
Pain Diagram

Please mark the area of injury or discomfort on the chart below

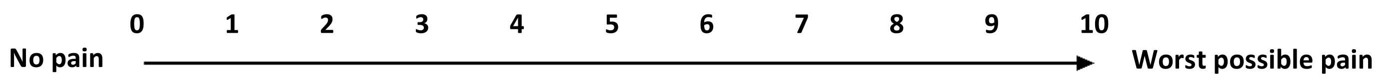


Back/Leg Pain

a. Indicate on the line below where your average pain level in your **back** is, ranging from no pain to the worst possible pain you can imagine.

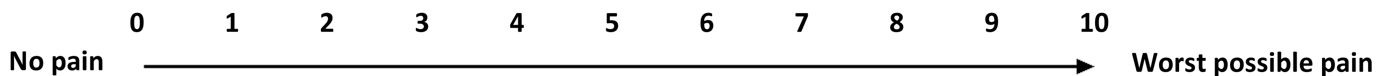
BACK PAIN at REST (please circle to which you are referring)

BACK PAIN with ACTIVITY (please circle to which you are referring)

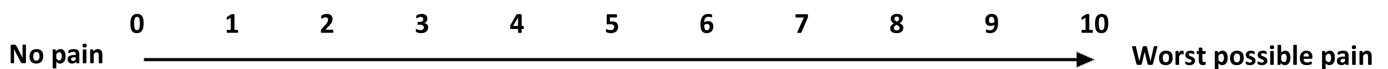


b. Indicate on the line below where your average pain level in your **leg(s)** is, ranging from no pain to the worst possible pain you can imagine.

LEG PAIN at REST (please circle to which you are referring)



LEG PAIN with ACTIVITY (please circle to which you are referring)



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During the **past week**, how bothersome have these symptoms **been**? (please circle to which you are referring)

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back and/or buttock pain	1	2	3	4	5	6
Leg pain	1	2	3	4	5	6
Numbness or tingling in leg and/or foot	1	2	3	4	5	6
Weakness in the leg and/or foot	1	2	3	4	5	6

Is your pain: ☐ Improving ☐ Staying the same ☐ Getting worse

What makes your symptoms

Worse: ______________________________

Better: ______________________________

Have you had any changes in your bowel or bladder function since the start of your back related symptoms?

☐ No ☐ Yes. Describe: ______________________________

Do you have any leg weakness?

☐ No ☐ Yes. Describe: ______________________________

Do you have any numbness in your legs?

☐ No ☐ Yes. Describe: ______________________________

What medication(s) do you take for your pain and how often do you take them?

Name of Drug	Dose	How many per day?	When did you start taking them?
☐ None			
☐ Tylenol or other over the counter drugs			
☐ Prescription Anti-Inflammatory			
☐ Tylenol #3 or #4			
☐ Percocet			
☐ Oxycontin or Morphine			
☐ Hydromorphone/Dilaudid			
☐ Other: ______________			

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Function

Employment Status:

What do you do for work? ______________________

Are you:

☐ Currently Working ☐ Modified Duties ☐ Student ☐ Retired

☐ Not Employed ☐ On Disability Benefits ☐ Other:________________

Are you satisfied with your job?

☐ Yes ☐ No. Describe: ________________________________

Is your job:

Physically Demanding ☐ No ☐ Yes. Describe: ________________________________

Mentally Demanding ☐ No ☐ Yes. Describe: ________________________________

What activities are limited by your pain?

☐ Light household duties ☐ Heavy household duties ☐ Self-care ☐ Dress ☐ Social life ☐ Travel

How often do you exercise? (e.g. 20 minutes or more of nonstop activity)

☐ Never, due to low back pain ☐ Never ☐ Once or less per week ☐ Twice or more per week

What recreational activities have you had to give up because of your pain? ______________________

____

Please check a unit of time or distance

How long can you SIT comfortably for?	______	☐ min	☐ hrs
How long can you STAND comfortably for?	______	☐ min	☐ hrs
How long can you WALK comfortably for?	______	☐ min	☐ km
How long can you SLEEP comfortably for?	______	hrs	

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Have you tried any treatments for your pain? Mark which apply

	When?	Very Helpful	Helpful	No Benefit	Worse
☐ Chiropractic		☐	☐	☐	☐
☐ Physiotherapy		☐	☐	☐	☐
☐ Massage		☐	☐	☐	☐
☐ Acupuncture		☐	☐	☐	☐
☐ Surgery		☐	☐	☐	☐
☐ Consultations		☐	☐	☐	☐
☐ Other		☐	☐	☐	☐

Have you had any investigations for your back problem? ☐ No ☐ Yes. See below

Type of Investigation:	☐ X-ray	☐ CT Scan	☐ MRI	☐ Bone scan	☐ EMG/Nerve Conduction
Date of Investigation:					

Past Medical History

Please indicate if you are currently or have been previously treated for the following conditions:

	Do you have the problem?	Do you receive treatment for it?	Does it limit your activity?
High Cholesterol	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
High Blood Pressure	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Stroke	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Coronary Artery Disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Asthma/Chronic Obstructive Pulmonary Disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Peripheral Vascular Disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Kidney disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Ulcer or stomach disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Anaemia or Other Blood Disease	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Depression	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Anxiety, bipolar disorder, obsessive compulsive disorder and panic disorder	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Osteoarthritis	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Other medical problems (please specify): ______	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
______	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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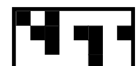

Patient Intake

Please list any medications (other than your pain medications) that you are currently taking (if any):

Medication	Dose	How many per day?	When did you start taking them?

Please list any surgical procedures you have had to date: ______________________

____

Do you have any allergies?

☐ No ☐ Yes. Describe: ______________________

Do you smoke?

☐ No ☐ Yes. How much? ______________________

☐ Quit. When? ______________________

What results do you expect from your participation in this programme (ISAEC) (mark one response on each line)

	Not at all likely	Slightly likely	Somewhat likely	Very likely	Extremely likely	Not applicable
Relief from symptoms	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
To do more everyday household or yard activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
To sleep more comfortably	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
To go back to my usual job	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
To exercise and do recreational activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
To prevent future disability	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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Oswestry Disability Index (ODI)

DIRECTIONS: Answer every question by marking the correct box. If you need to change an answer, completely scratch out the incorrect answer and mark the correct box. If you are unsure about how to answer a question, please give the best answer you can. Mark only one answer for each question unless instructed otherwise.

1. PAIN INTENSITY:

- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain, I do not use them.

2. PERSONAL CARE (WASHING, DRESSING, ETC):

- ☐ I can look after myself normally without it 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 manage most of my personal care.
- ☐ I need help everyday in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

3. LIFTING:

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. 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 at all.

4. WALKING:

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 1/2 mile.
- ☐ Pain prevents me walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

5. SITTING:

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than thirty minutes.
- ☐ Pain prevents me from sitting more than ten minutes.
- ☐ Pain prevents me from sitting at all.

6. STANDING:

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than one hour.
- ☐ Pain prevents me from standing more than thirty minutes.
- ☐ Pain prevents me from standing more than ten minutes.
- ☐ Pain prevents me from standing at all.

7. SLEEPING:

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

8. EMPLOYMENT/HOMEMAKING:

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties 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.

9. SOCIAL LIFE:

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

10. TRAVELING:

- ☐ I can travel anywhere without extra 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 journeys under thirty minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

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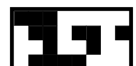


Patient Intake

EuroQol (EQ-5D)

By placing a tick in one box in each group below, please indicate which statements best describes your own health state **TODAY**:

a. MOBILITY:
- ☐ I have no problems walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

b. SELF-CARE:
- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

c. USUAL ACTIVITIES (eg., work, study, housework, family or leisure activities):
- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

d. PAIN/DISCOMFORT:
- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

e. ANXIETY:
- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

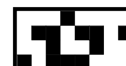
Connor-Davidson Resilience Scale 2
(CD-RISC 2)

1. I am able to adapt when changes occur.

☐ 0 Not true at all ☐ 1 Rarely true ☐ 2 Sometimes true ☐ 3 Often true ☐ 4 True nearly all the time

2. I tend to bounce back after illness, injury, or other hardships.

☐ 0 Not true at all ☐ 1 Rarely true ☐ 2 Sometimes true ☐ 3 Often true ☐ 4 True nearly all the time



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Self-Efficacy of Managing Chronic Disease Questionnaire

1. **How confident are you that you can keep the fatigue caused by your condition from interfering with the things you want to do?**

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

2. **How confident are you that you can keep the physical discomfort or pain of your condition from interfering with the things you want to do?**

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

3. **How confident are you that you can keep the emotional distress caused by your condition from interfering with the things you want to do?**

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

4. **How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?**

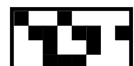
Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

5. **How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?**

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident

6. **How confident are you that you can do things other than just taking medication to reduce how much your condition affects your everyday life?**

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident



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STarT Back: For these questions, please think about your back pain over the last few days.

1. How **bothersome** has **pain spreading down your legs from your back** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	1	2	3	4

2. How **bothersome** has pain in your **shoulder or neck** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	1	2	3	4

For each of the following, please cross one box to show how much you agree or disagree with the statement, thinking about the **last few days**.

3. In the last **few days**, I have **dressed more slowly** than usual because of my back pain.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

4. In the last **few days**, I have only **walked short distances** because of my back pain.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

5. It's **really not safe** for a person with a condition like mine to be **physically active**.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

6. **Worrying thoughts** have been going through my mind a lot of the time in the last **few days**.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

7. I feel that **my back pain is terrible** and that **it is never going to get any better**.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

8. In general, in the last **few days**, I have **not enjoyed** all the things I used to enjoy.

Completely disagree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Strongly agree
	0	1	2	3	4	5	6	7	8	9	10	

9. Overall, how **bothersome** has your **back pain** been in the last **few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	1	2	3	4