Clinical Outcome Intake Form — for new spine patients on first visit

Your care is very important to us. For us to manage your care, please answer all questions on this form.

INITIAL PATIENT ASSESSMENT
FOR FIRST VISIT ONLY

1 Patient information

____ /____/____ Today's Date (M/D/Y)

First name _____ Last name _____

___-___-____ Phone number (A nurse may call to follow up)
☐ Day ☐ Evening

Doctor you see today _____

How did you first hear of us?
- ☐ Friend/relative/word-of-mouth
- ☐ Newspaper/magazine
- ☐ Internet/web site
- ☐ Health insurance directory
- ☐ Yellow Pages/phone book
- ☐ Dr: _____

Your age: ☐ <18 ☐ 18-64 ☐ 65+

Sex: ☐ Male ☐ Female

Do you smoke? ☐ Yes ☐ No

2 Your symptoms

Which of the following do you have? (Check all that apply)
- ☐ Back pain ☐ Neck pain
- ☐ Tingling in arm or leg ☐ Weakness in arm or leg

How long have you suffered from these symptoms?
- ☐ ≤ 6 weeks ☐ 7 to 12 weeks ☐ 4 months or more

Do you have pain radiating PAST your knee or elbow?
- ☐ Yes ☐ No

Does your leg or arm ever go numb?
- ☐ Yes ☐ No

Have you had back or neck surgery before?
- ☐ Yes ☐ No

Does your back or neck pain wake you up at night?
- ☐ Yes ☐ No

How many pills do you take each day for pain relief?
- ☐ No pills ☐ 1 to 4 pills ☐ 5 or more pills daily

Circle your pain level on a scale of 1 to 10, with 1 being no pain at all, and 10 being extreme pain.

1 2 3 4 5 6 7 8 9 10
no pain extreme pain

3 Your expectations

What result do you expect from your care?

Relief from pain symptoms	☐ Yes	☐ No	☐ Doesn't apply
Return to your job	☐ Yes	☐ No	☐ Doesn't apply
Return to leisure activities	☐ Yes	☐ No	☐ Doesn't apply
Improved sleep	☐ Yes	☐ No	☐ Doesn't apply

4 How do symptoms affect your life?

Which of the following describes you currently?
- ☐ Working
- ☐ Not working because of back or neck problem
- ☐ Not working because of another health problem
- ☐ Homemaker, retired or unemployed

Did your back or neck injury happen at work? ☐ Yes ☐ No

If you are not working, how long have you been off work because of your back or neck problem?
- ☐ Less than 1 month ☐ Longer than 1 month

Describe the activities involved in your job that you have now, or hope to return to: (Check all that apply)
- ☐ Heavy/frequent lifting ☐ Prolonged sitting or driving
- ☐ Pushing/pulling ☐ Prolonged standing

The following are activities you might do in a typical day. Does your back or neck pain limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	Not limited at all
Strenuous activities... like running, lifting heavy objects	☐ 1	☐ 2	☐ 3
Moderate activities... like housework, pushing a vacuum, playing golf	☐ 1	☐ 2	☐ 3
Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
Climbing several flights of stairs	☐ 1	☐ 2	☐ 3
Walking for 30 minutes	☐ 1	☐ 2	☐ 3
Sitting for 30 minutes	☐ 1	☐ 2	☐ 3
Standing for 30 minutes	☐ 1	☐ 2	☐ 3
Getting dressed, bathing	☐ 1	☐ 2	☐ 3

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We may have a nurse call you to follow up on your symptoms and check to see how you are doing 3 months from now. Is it okay for us to call you at the number you provided above? ☐ Yes ☐ No