Back Index

Form BI100

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

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

Sleeping

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

Sitting

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

Standing

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

Walking

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

Personal Care

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

Lifting

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

Traveling

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

Social Life

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

Changing degree of pain

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

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

Back Index Score _____

MEDICAL HISTORY FORM

1. Name

Last	First	MI

2. Are you: ☐ Right-handed ☐ Left-handed

3. Employment

☐ Work outside of home ☐ Student
☐ Homemaker ☐ Retired
☐ Unemployed

Occupation: _____

How many hours do you spend in computer/desk work per day?_____

How much and how often do you lift objects heavier than 10 pounds?

# of times/day: _____
Average weight of objects lifted: _____

4. Where do you live?

☐ Private home ☐ Private apartment
☐ Board & care / assisted living / group home
☐ Other _____

5. With whom do you live?

☐ Alone ☐ Spouse
☐ Child ☐ Other relative
☐ Pets ☐ Other _____
☐ Personal care attendant
☐ 24-hour ☐ Part-time

6. Does your home have:

☐ Stairs ☐ Ramps
☐ Elevator

7. Do you use:

☐ Cane ☐ Walker ☐ Other _____

8. Do you have any vision or hearing problems? ☐ Yes ☐ No

Do you use:

☐ Glasses/Contacts ☐ Hearing Aid

9. Medications

Do you currently take any prescription medications?

☐ Yes ☐ No If yes, please list: _____

_____

_____

_____

Do you currently take any nonprescription medications?

☐ Antacids ☐ Ibuprofen/ Naproxen
☐ Antihistamines ☐ Laxatives
☐ Aspirin ☐ Tylenol
☐ Decongestants ☐ Vitamins
☐ Herbal supplement

Other _____

10. Health Habits

Please rate your health:

☐ Excellent ☐ Good
☐ Fair ☐ Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

☐ Yes

Please describe the exercise, sport or hobby: _____

_____

_____

How many days per week do you exercise or do physical activity? _____

For how many minutes, on an average day? _____

☐ No

Do you currently use or have you previously used tobacco?

☐ Yes Cigarettes, # of packs/day _____
Cigars, # per day _____
Chewing tobacco_____
Year quit: _____

☐ No

How many days per week do you drink beer, wine, or other alcoholic beverages? _____

How many caffeinated beverages do you drink on an average day? _____

Do you have a history of chemical dependency?

☐ Yes ☐ No

11. Within the past year, have you had any of the following medical tests?

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Pulmonary function test
☐ Stress test (such as treadmill, bicycle)
☐ X-rays

Therapist comments: _____

_____

_____

_____

Therapist signature: _____

CONTINUE ON OTHER SIDE

12. Medical History

Please check if you have had:	Yes	No
Allergies		
Arthritis		
Bladder problems (including repeated infections, urinary incontinence, leaking)		
Blood disorders (including hemophilia/anemia)		
Bone/joint infections		
Broken bones/fractures		
Cancer		
Circulation/vascular		
Depression		
Developmental or growth problems		
Diabetes or problems with blood sugar		
Fibromyalgia		
Head injury		
Heart problems (Pacemaker)		
High blood pressure		
Infectious diseases (such as tuberculosis, hepatitis, HIV)		
Kidney problems		
Liver problems		
Lung problems (including asthma)		
Metal implants		
Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)		
Osteoporosis		
Seizures/epilepsy		
Sensitivity to latex rubber		
Skin diseases		
Thyroid problems		
Ulcers/stomach problems		
Other: _____.		

For men:

Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No

For women:

Have you ever been diagnosed with:

☐ Pelvic inflammatory disease? ☐ Endometriosis? ☐ Trouble with your period?

☐ Complicated pregnancies/deliveries?

Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

13. Have you ever had surgery?

☐ Yes ☐ No

If yes, please describe and include dates: ____

_____

_____

_____

14. Within the past year, have you had any of the following symptoms?

☐ Bowel problems
☐ Chest pain
☐ Coordination problems
☐ Chronic cough
☐ Difficulty sleeping
☐ Dizziness or blackouts
☐ Fever/chills/ sweats
☐ General malaise
☐ Headaches
☐ Hearing problems
☐ Heart palpitations
☐ Hoarseness
☐ Loss of appetite
☐ Loss of balance or falls
☐ Nausea/ vomiting
☐ Pain during the night
☐ Sexual dysfunction
☐ Shortness of breath
☐ Urinary problems or change in frequency
☐ Vision problems
☐ Weakness in arms or legs
☐ Weight loss/gain

15. Are you currently seeing anyone else for this diagnosis?

☐ Acupuncturist
☐ Athletic trainer
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family doctor
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician/ gynecologist
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other _____

If you see another health professional for this problem, may the physical therapist discuss your case with him or her? ☐ Yes ☐ No

Patient Signature: _____

Date: ____/____/____

Therapist comments: _____

_____

_____

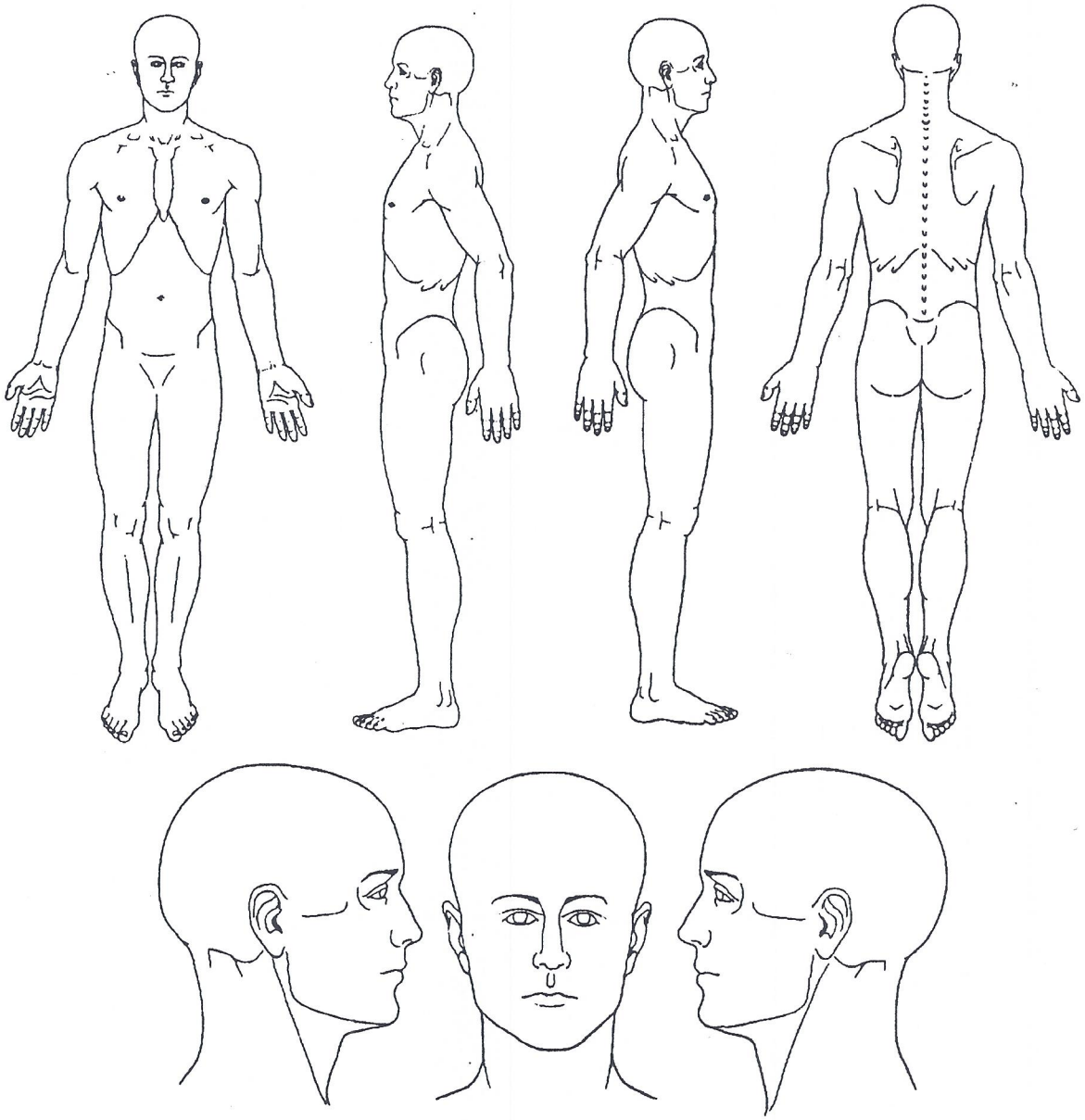
_____

Therapist signature: _____

Pain Assessment Form

Pain Diagram

At this time, where is your pain?
Please mark on the drawings the area where you feel pain (circle or mark with crosses)



PAIN RATING (On scale of 0 to 10, with 10 the worst)

Current:

Best:

Worst: