Tonawanda Chiropractic and Rehabilitation
1201 Colvin Blvd Buffalo, NY 14223
P: (716)490-0210

New Patient – Lower Back – Patient

Welcome to Tonawanda Chiropractic and Rehabilitation! Please take the next few minutes to complete this questionnaire. We want you to know that it is our sincere desire to help you in any way we can and your answers will assist us in this process. Thank you.

Name_____ Date_____
Address_____
City_____ State_____ Zip_____
Home Telephone_____ Work Telephone_____
Mobile_____ Email_____
Date of Birth_____ Age_____ Marital Status S M D W Partner
Occupation_____ Employer_____
Spouse/Partner Name_____ Emergency Contact Name_____
Emergency Contact Number_____

How would you like to be addressed by our staff? _____
Whom may we thank for referring you to our office? _____

What is the nature of your complaint? _____
_____
_____
_____

When did it first occur? _____
_____
_____

Other complaints? _____
_____
_____

Does your present condition involve a claim for:
-a job injury (worker's comp)? _____ if so, in what state? _____
-auto accident/other personal injury accident?_____ if so, in what state? _____

Have you lost time from work for this incident? YES / NO Exact dates_____
Have X-rays/MRI/been taken for this incident? 1) X-ray: Y / N Date:_____ 2) MRI: Y / N Date:_____

Have you ever consulted a Chiropractic Physician before? YES / NO
Name of Chiropractor/Office_____ Last visit_____

Do you have a Primary Care Physician? YES / NO Name_____
When was your last physical examination? _____
What was your reason for having it? _____
Most recent order of blood tests_____

May we contact you at home/work and leave messages? YES / NO

PAST MEDICAL HISTORY: Please mark with a check any of the following illnesses you have had or currently have and indicate when. (If not certain of dates, please give approximate dates)

- ☐ High Blood Pressure_____
- ☐ Heart Disease_____
- ☐ Stroke(s)_____
- ☐ Diabetes_____
- ☐ Kidney Disease_____
- ☐ HIV_____
- ☐ Prostate Disease_____
- ☐ Venereal Disease_____
- ☐ Allergies_____
- ☐ Scoliosis_____
- ☐ Mental/Emotional_____
- ☐ Seizures_____
- ☐ Multiple Sclerosis_____
- ☐ Ulcer(s)_____
- ☐ Cancer(s)_____
- ☐ Serious injuries/fall(s)_____
- ☐ Auto Accident(s)_____
- ☐ Other_____

Is there anything else in your medical history we should know? _____

_____

_____

List times/reasons you have been hospitalized. Do **NOT** list normal pregnancies.

Year	**Reason**	**Hospital**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications you are presently taking (if you have a list, please give it to receptionist):

Medication	**Reason**	**Medication**	**Reason**
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

FAMILY HISTORY:

Has anyone in your **immediate** family (father, mother, siblings, children) had any of the following illnesses? Please list which family members have had each.

High Blood Pressure_____

Heart Disease_____

Stroke(s)_____

Diabetes_____

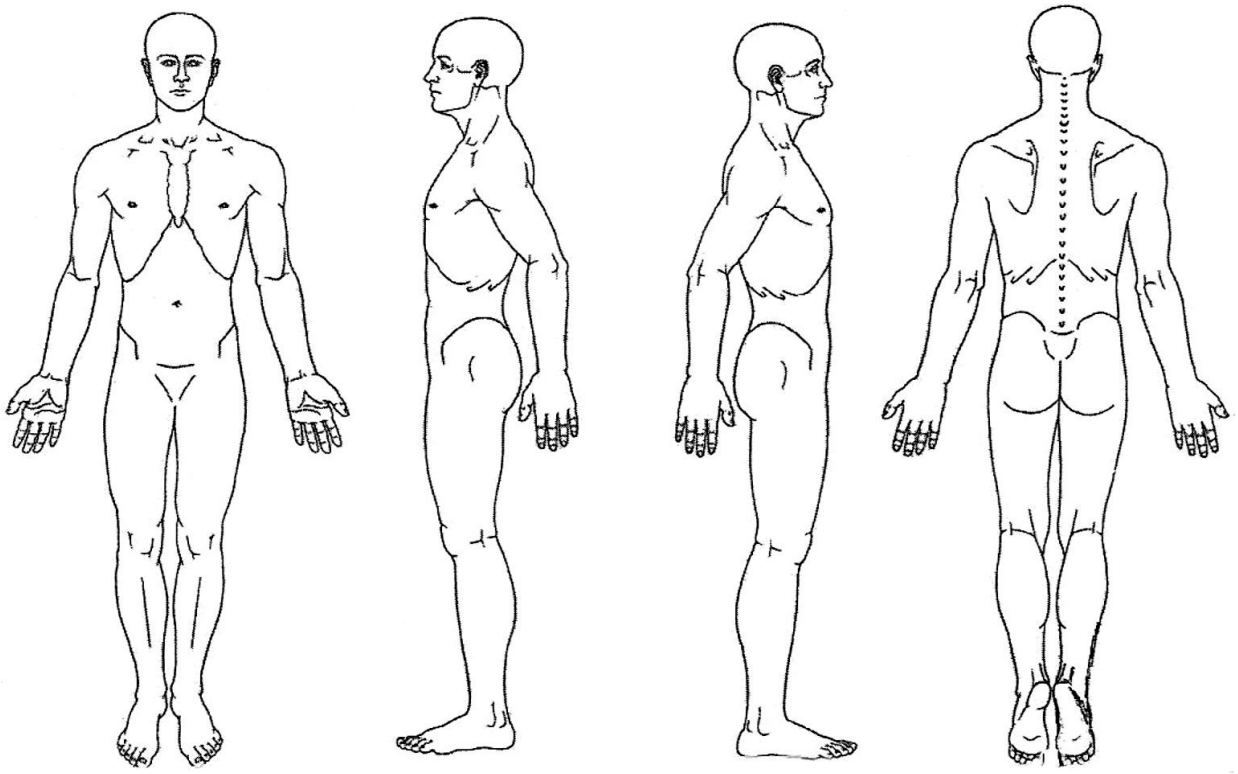
Cancer(s)_____

Other_____

If you have children, how many do you have? _____ How many live with you? _____

Signature_____ Date_____

Using the following descriptive symbols, draw the location of your pain on the body outlines below.



ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^^^^	========	OOOOOOO	……..	///////////	XXXXXXXX

Please circle the appropriate number. Remember you must only circle one number along the scale.

Over the past week, on average, how would you rate your back pain?

0	1	2	3	4	5	6	7	8	9	10

No pain *Worst pain*

How confident are you in your ability to overcome you back pain problem?

0	1	2	3	4	5	6	7	8	9	10

Total confidence *No confidence*

How depressed do you feel as a result of your back pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all *Extremely*

Based on all the things you do to cope or deal with your back pain, on an average day, how much control do you feel you have over it?

0	1	2	3	4	5	6

No control *Some* *Complete control*

Based on all the things you do to cope or deal with your back pain, on an average day, how much are you able to decrease it?

0	1	2	3	4	5	6

Can't decrease it all *Can decrease somewhat* *Can decrease it completely*

What are two important activities that you cannot do or are having trouble doing because of your back pain? (ex: “I can’t get dressed without help,” “I can’t play golf,” “I can’t go to work.”)

Activity #1_____

Please rate your activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — Unable to perform

Activity #2_____

Please rate your activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — Unable to perform

Signature_____ Date_____

Keele STarT Back Screening Tool – 9 Item

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**?

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

2) How **bothersome** has **pain in your hips or back** been in the **last few days**?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Total score (all 9):_____ Sub-score (Q5-9):_____

Signature_____ Date_____

Low Back Pain and Disability Questionnaire (Revised Oswestry)

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage everyday life. Please answer every section by marking **ONLY the one box which applies to how your back pain is affecting you** and not as it relates to any other health problems you may have. We realize that you may consider more than one statement may relate to you, but please just mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my ways of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I an unable to do any washing and dressing without help.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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 at the most.

SECTION 4 – WALKING

- ☐ I have no pain when walking.
- ☐ I have some pain when walking, but it does not decrease my distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more then ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING

- ☐ I can sit in a chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6 – STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain when standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7 – SLEEPING

- ☐ I get no pain while in bed.
- ☐ I get pain while in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night sleep is reduced by about 25%.
- ☐ Because of pain, my normal night sleep is reduced by about 50%.
- ☐ Because of pain, my normal night sleep is reduced by about 75%.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has not significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted by social life, and I do not go out very often.
- ☐ Pain has restricted my social life to my house.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – TRAVELING

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which requires me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done by lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ There has been no change in my pain.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Signature:_____

Date:_____