Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE

To help us better understand your medical history, please mark Yes or No if you have or have had the below symptoms/diagnoses and fill in all pertinent blank spaces.

Cardiovascular disease	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Smoking	❑ Yes ❑ No	Rheumatoid arthritis	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Osteoporosis/ Osteopenia	❑ Yes ❑ No
High cholesterol	❑ Yes ❑ No	Osteoarthritis	❑ Yes ❑ No
Emphysema or Bronchitis	❑ Yes ❑ No	Blurred vision	❑ Yes ❑ No
History of stroke or TIA	❑ Yes ❑ No	Dizziness/vertigo	❑ Yes ❑ No
Persistent cough	❑ Yes ❑ No	Double vision	❑ Yes ❑ No
Chest pain	❑ Yes ❑ No	Difficulty talking/swallowing	❑ Yes ❑ No
Shortness of breath	❑ Yes ❑ No	Headache	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Kidney disease	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Immune disorder	❑ Yes ❑ No
Abdominal pain	❑ Yes ❑ No	Active Herpes, Shingles	❑ Yes ❑ No
Change in hair or nail growth	❑ Yes ❑ No	Change in bowel or bladder	❑ Yes ❑ No
Stomach ulcers	❑ Yes ❑ No	Incontinence	❑ Yes ❑ No
Fever/chills/sweats	❑ Yes ❑ No	Sudden loss of consciousness	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Unexplained weakness	❑ Yes ❑ No	Confusion	❑ Yes ❑ No
Unexplained weight loss/gain	❑ Yes ❑ No	Multiple sclerosis	❑ Yes ❑ No
Thyroid problems	❑ Yes ❑ No	Depression	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Chemical dependency	❑ Yes ❑ No
Liver disease	❑ Yes ❑ No	Tingling/numbness at the inner thigh	❑ Yes ❑ No

During the past month, have you often been bothered by feeling down, depressed or hopeless?	❑ Yes ❑ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	❑ Yes ❑ No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?	❑ Yes ❑ No
Do you have a history of cancer?	❑ Yes ❑ No Explain:
Do you have a current infection:	❑ Yes ❑ No Explain:
Have you noticed discoloration in urine or stool?	❑ Yes ❑ No
Does eating certain foods make your pain worse?	❑ Yes ❑ No

Please complete on reverse side →

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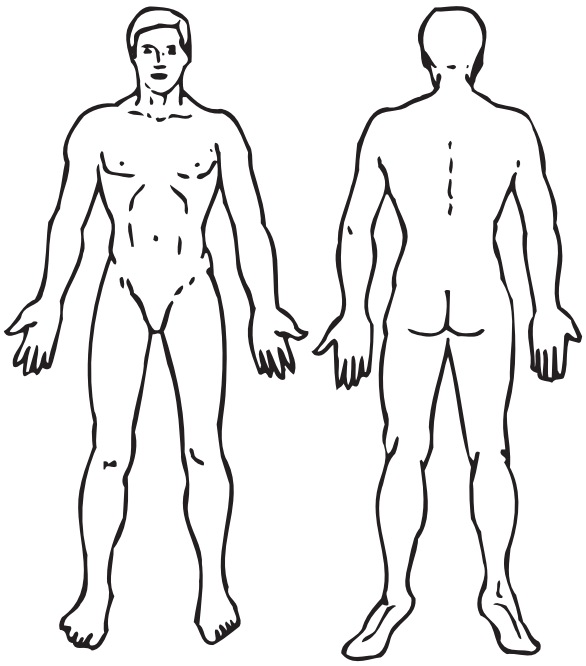
STANFORD, CALIFORNIA 94305

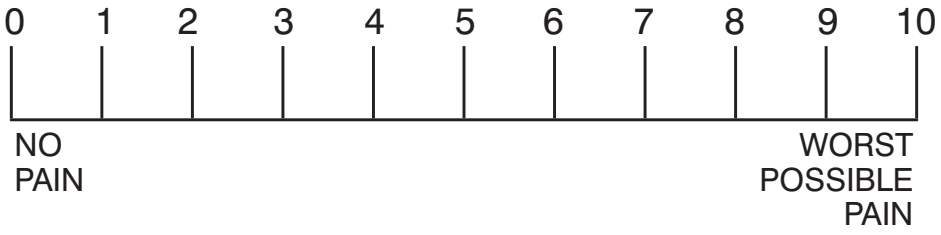
CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE

This pain drawing will help us to understand the pain that you have been experiencing. Please diagram the location of your pain.



Right Left Left Right

Please mark your current pain intensity:



DATE TIME SIGNATURE (Patient, or Properly Designated Representative)

PRINT NAME RELATIONSHIP TO PATIENT

Provider: Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key find(s) with the patient and/or family. Key finding (s) must be summarized in your progress note; however, the questionnaire should be referenced for additional details.

DATE TIME PROVIDER/TITLE PRINT NAME

Medical Record Number

Patient Name

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CLINICS REHAB PATIENT-SPECIFIC FUNCTIONAL SCALE QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____

Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your pain. Use the scale immediately below the activity and rate the degree of limitation for each of the activities you list by circling one of the options:

0 – unable to perform activity
10 – able to perform activity at same activity level as before this problem

ACTIVITY #1: _____

0	1	2	3	4	5	6	7	8	9	10

ACTIVITY #2: _____

0	1	2	3	4	5	6	7	8	9	10

ACTIVITY #3: _____

0	1	2	3	4	5	6	7	8	9	10

TOTAL SCORE: Sum of activity scores/number of activities to get mean score _____/_____
MDC (90% CI) avg score = 2 points MDC (90%) CI Single activity = 3 points

Comments: _____

Patient Signature	Patient Print Name	Date	Time

Person completing form if other than patient	Relationship to Patient

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Provider Signature/Title	Provider Print Name	Date	Time

MDC = Minimal Detectable Change
CI = Confidence Interval

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CLINICS MODIFIED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one box** that best describes your condition today. We realize you may feel that **two** (2) of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

SECTION 1 - PAIN INTENSITY

- ❑ I can tolerate the pain I have without having to use pain medication.
- ❑ The pain is bad, but I can manage without having to take pain medication.
- ❑ Pain medication provides me with complete relief from pain.
- ❑ Pain medication provides me with moderate relief from pain.
- ❑ Pain medication provides me with little relief from pain.
- ❑ Pain medication *has* no effect on my pain.

SECTION 2 – PERSONAL CARE (eg. Washing, Dressing)

- ❑ I can take care of myself normally without causing increased pain.
- ❑ I can take care of myself normally, but it increases my pain.
- ❑ It is painful to take care of myself, and I am slow and careful.
- ❑ I need help, but I am able to manage most of my personal care.
- ❑ I need help every day in most aspects of my care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights, but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights 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 lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WALKING

- ❑ Pain does not prevent me from walking any distance.
- ❑ Pain prevents me from walking more than 1 mile (= 1.6 km).
- ❑ Pain prevents me from walking more than ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk with crutches or a cane.
- ❑ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – SITTING

❑ I can sit in any chair as long as I like.
❑ I can only sit in my favorite chair as long as I like.
❑ Pain prevents me from sitting for more than 1 hour.
❑ Pain prevents me from sitting for more than ½ hour.
❑ Pain prevents me from sitting for more than 10 minutes.
❑ Pain prevents me from sitting at all.

SECTION 6 – STANDING

❑ I can stand as long as I want without increased pain.
❑ I can stand as long as I want, but it increases my pain.
❑ Pain prevents me from standing more than 1 hour.
❑ Pain prevents me from standing more than ½ hour.
❑ Pain prevents me from standing more than 10 minutes.
❑ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

❑ Pain does not prevent me from sleeping well.
❑ I can sleep well only by using pain medication.
❑ Even when I take pain medication, I sleep less than 6 hours.
❑ Even when I take pain medication, I sleep less than 4 hours.
❑ Even when I take pain medication, I sleep less than 2 hours.
❑ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

❑ My social life is normal and does not increase my pain.
❑ My social life is normal, but it increases my level of pain.
❑ Pain prevents me from participating in more energetic activities (e.g. sports, dancing).
❑ Pain prevents me from going out very often.
❑ Pain has restricted my social life to my home.
❑ I have hardly any social life because of my pain.

SECTION 9 – TRAVELING

❑ I can travel anywhere without increased pain.
❑ I can travel anywhere, but it increases my pain.
❑ My pain restricts my travel over 2 hours.
❑ My pain restricts my travel over 1 hour.
❑ My pain restricts my travel to short necessary journeys under ½ hour.
❑ My pain prevents all travel except for visits to the physician/ therapist or hospital.

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CLINICS MODIFIED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

SECTION 10 – 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 (e.g. 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.

Scoring: Questions are scored on a vertical scale of 0 - 5.
SCORE _____ [50] **MCID = ± 4 to 6 point (8% - 12%)**
(Minimal Clinical Important Difference)

Patient Signature	Patient Print Name	Date	Time

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Provider Signature/Title	Provider Print Name	Date	Time