RAPID ACCESS CLINIC
LOW BACK PAIN

PATIENT INTAKE Date: dd/mm/yy

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

Back Specific History

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

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

During the *past week*, how bothersome have these symptoms *been*:

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back and/or buttock pain	☐	☐	☐	☐	☐	☐
Leg pain	☐	☐	☐	☐	☐	☐
Numbness or tingling in leg	☐	☐	☐	☐	☐	☐
Weakness in the leg and/or foot	☐	☐	☐	☐	☐	☐

How long have you had your current episode of low back related symptoms?
☐ < 6 weeks ☐ 6 – 12 weeks ☐ 3 – 6 months ☐ 6 – 12 months ☐ > 12 months ☐ N/A

Is your pain: ☐ Improving ☐ Staying the same ☐ Worsening

Have you had back problems before your current episode of back symptoms? ☐ Yes ☐ No

What makes your symptoms better? (mark all that apply)
☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Heat/Cold ☐ Bending Forwards
☐ Medication ☐ Rest ☐ Activity ☐ Stretching ☐ Exercise ☐ Bending Backwards
☐ Sessions with a physio/chiro etc. ☐Other. Please specify ______________________________

What makes your symptoms worse? (mark all that apply)
☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Bending Forwards ☐ Bending Sideways
☐ Lifting ☐ Inactivity ☐ Coughing ☐ Sneezing ☐ Bending Backwards
☐ Other. Please specify: ____

Have you had any changes in your bowel or bladder function since the start of your low back symptoms?
☐No ☐Yes. Describe: ____

Because 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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Ontario

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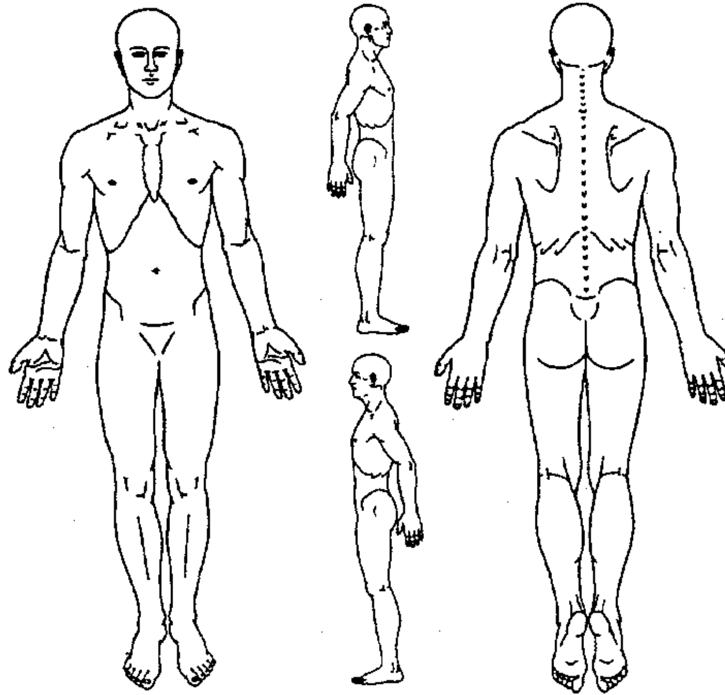
Pain Diagram - Please mark the area of injury or discomfort on the chart below



Indicate below how you would rate your average pain level during the past week in your back and leg(s) (as applicable), ranging from **'No pain'** to **'Worst possible pain you can imagine'.**

Back pain <u>at its best</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — *Worst possible pain*

Back pain <u>at its worst</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — *Worst possible pain*

Leg pain <u>at its best</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — *Worst possible pain*

Leg pain <u>at its worst</u>:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain — *Worst possible pain*

How long can you comfortably?

Activity:	**Sit**	**Stand**	**Walk**	**Sleep**
Time:	____________ mins	____________ mins	____________ mins	____________ hrs

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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: ___________________________			

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

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

	☐ X-ray	☐ CT Scan	☐ MRI	☐ Bone scan	☐ EMG
Date of Investigation:					

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

Treatment	Helpful	No Benefit
☐ Chiropractic	☐	☐
☐ Physiotherapy	☐	☐
☐ Massage	☐	☐
☐ Acupuncture	☐	☐
☐ Other	☐	☐

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

Employment Status:

☐ Currently Working ☐ Modified Duties ☐ Student ☐ Other: ___________________
☐ Not Employed ☐ On Disability Benefits ☐ Retired

If employed, what do you do for work? ____

Does the nature of your work involve? (Mark all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Carrying ☐ Bending ☐ Twisting
☐ Driving ☐ Other. Please specify: ____

I have support from people who can assist me with activities in the home, work or community? (check one)

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

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Medical History. Please indicate if you are currently being treated for any of the following conditions:

Conditions (mark all that apply)	Does it limit your function?	Conditions (mark all that apply)	Does it limit your function?
☐ High Cholesterol	☐No ☐Yes	☐ Diabetes	☐No ☐Yes
☐ High Blood Pressure	☐No ☐Yes	☐ Kidney Disease	☐No ☐Yes
☐ Stroke	☐No ☐Yes	☐ Liver Disease	☐No ☐Yes
☐ Heart Attack/Coronary Artery Disease	☐No ☐Yes	☐ Ulcer or Stomach Disease	☐No ☐Yes
☐ Heart Failure	☐No ☐Yes	☐ Thyroid Disease	☐No ☐Yes
☐ Lung Disease (e.g. asthma, COPD)	☐No ☐Yes	☐ Depression	☐No ☐Yes
☐ Anaemia or Other Blood Disease	☐No ☐Yes	☐ Anxiety	☐No ☐Yes
☐ Cancer	☐No ☐Yes	☐ Chronic Neck Pain	☐No ☐Yes
☐ Dementia	☐No ☐Yes	☐ Migraine Headaches	☐No ☐Yes
☐ Osteoarthritis/Degenerative Arthritis	☐No ☐Yes	☐ Chronic Pelvic Pain	☐No ☐Yes
☐ Rheumatoid Arthritis	☐No ☐Yes	☐ Fibromyalgia	☐No ☐Yes

☐ Other Medical Problems (please specify): ________________________________	☐No ☐Yes

Please list *current prescribed* medications:

____

____

Please list previous surgeries: ____

____

Do you have any drug allergies? ☐No ☐Yes. Describe ____________________________

Do you smoke? ☐ No ☐Yes. How much? ____________ ☐Quit. When? ____________

What results do you hope to achieve from your visit today? (Mark one response on each line)

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

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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 have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

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 1 hour.
- ☐ Pain prevents me from standing more than 1/2 an hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

2. PERSONAL CARE (WASHING, DRESSING, ETC):
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

7. SLEEPING:
- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours sleep.
- ☐ Because of pain I have less than 4 hours sleep.
- ☐ Because of pain I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

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 lift only very light weights.
- ☐ I cannot lift or carry anything at all.

8. SEX LIFE (if applicable):
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life 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.

9. SOCIAL LIFE:
- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, sports)
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain

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 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

10. TRAVELLING:
- ☐ I can travel anywhere without 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 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment

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EQ-5D

Under each heading, please tick the **ONE** box that best describes your health **TODAY:**

MOBILITY:

☐ I have no problems walking about
☐ I have slight problems in walking about
☐ I have moderate problems in walking about
☐ I have severe problems in walking about
☐ I am unable to walk about

SELF-CARE:

☐ I have no problems washing or dressing myself
☐ I have slight problems washing or dressing myself
☐ I have moderate problems washing or dressing myself
☐ I have severe problems washing or dressing myself
☐ I am unable to wash or dress myself

USUAL ACTIVITIES (eg., work, study, housework, family or leisure activities):

☐ I have no problems doing my usual activities
☐ I have slight problems doing my usual activities
☐ I have moderate problems doing my usual activities
☐ I have severe problems doing my usual activities
☐ I am unable to do my usual activities

PAIN/DISCOMFORT:

☐ I have no pain or discomfort
☐ I have slight pain or discomfort
☐ I have moderate pain or discomfort
☐ I have severe pain or discomfort
☐ I have extreme pain or discomfort

ANXIETY/DEPRESSION:

☐ I am not anxious or depressed
☐ I am slightly anxious or depressed
☐ I am moderately anxious or depressed
☐ i am severely anxious or depressed
☐ I am extremely anxious or depressed

STarT Back

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1. My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2. I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3. I have only **walked short distances** because of my back pain	☐	☐
4. In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5. It's not really safe for a person with a condition like mine to be physically active	☐	☐
6. **Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7. I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8. In general, I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): ________________________ **Sub Score (Q5-9):**__________________________

SPINEgroup

INFORMED CONSENT & PERMISSION TO DISCLOSE HEALTH INFORMATION

I. We are seeking **Informed Consent** for the health services we provide including: chiropractic, private physiotherapy, publicly-funded physiotherapy, massage therapy, podiatry, nursing, dietary, psychological, naturopathic, medical, and/or acupuncture services. Your treating health provider(s) within your "circle of care" are authorized to share your **Personal Health Information** ("PHI") for the purpose of collaborative management of your care. We always use all reasonable efforts to ensure privacy when entering your PHI in our common e-health record or EMR system such that your PHI information is not misunderstood, misused or lost by any health provider who may have access to your electronic patient chart.

II. Requests for services will begin with an initial clinical assessment. Feedback will be provided with suggestions given as to the course of treatment in terms of type, provider, length, plan and general approach. Referrals to other professionals outside the clinic may be made. Any changes in the type of treatment service to be provided in the future will be discussed with you in advance.

III. Only pre-sterilized needles are used. All acupuncture needles are properly disposed of after each and every treatment.

IV. There are risks and possible risks associated with orthopedic evaluation, functional assessments, acupuncture, manual therapy, mechanical traction, use of rehabilitation equipment and rehabilitation conducted by doctors of chiropractic, physiotherapists, acupuncturists, massage therapists or registered nurses. In particular, you should note:

a) While rare, some patients may experience aggravation of symptoms or muscle and ligament strains or sprains, bruising or irritation as a result of manual therapy, injection therapy, shockwave therapy, rehabilitation, acupuncture or in rare circumstances; orthopedic or functional evaluation. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures, including spinal manipulation.
b) I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding, or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.
c) Recent studies, etc. suggest that patients may be consulting medical doctors, nurses, physiotherapists, and chiropractors when they are in the early stages of a stroke (a stroke already in progress). You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical manipulation is extremely remote and occurs infrequently. Please inform your treating provider immediately if you experience any unusual neurological symptoms, severe head, jaw and/or neck pain.
d) There are rare reported cases of disc or spinal injuries identified following cervical and lumbar spinal manipulation, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal manipulation. In some circumstances, manual therapy/spinal manipulation may aggravate an already existing degenerative disc condition.
e) There are infrequent reported cases of burns or skin irritation in association with the use of some types of ultrasound, electrical therapy, shockwave and laser therapy.

V. There are possible risks associated with assessments or counseling (nursing, chiropractic, occupational, vocational or psychological) including, the rousing of upsetting feelings. You are encouraged to advise your health provider if these should arise.

VI. There are risks associated with rehabilitation and the use of rehabilitation or exercise equipment at the facility. Risks include but not limited to muscle/ligament straining and falls, even under supervision. Vestibular and stability training through the use of therapy balls, rocker boards, vibration therapy, etc. pose a risk for falls thus proper footwear and padded environment must be maintained. The clinic provides rubber flooring in the rehab area and mats for protection. The patient assumes risk of injury when undergoing rehabilitation/exercise therapy.

VII. Disclosure of Personal Health Information: *Confidentiality and Privacy is respected at all times.* Sessions with all healthcare providers at SPINEgroup® and the information discussed are **confidential**; that is, the contents of a session, or even whether or not you attend, will not be revealed to outside sources unless you have given written consent/permission to do so, or as required by law. You maintain the right to review your PHI and patient file (which will be held in a secure location for a minimum of 10 years, after the last date of contact or 10 years after a patient's 18th birthday). Exceptions to confidentiality include the legal and/or ethical obligations to report as follows:

a) Inform a potential victim of violence of a client's intention to harm (if you are in, or appear to be in imminent danger of doing serious harm to yourself or another person);

b) Inform an appropriate family member, health care professional or police if necessary of a client's intention to end his or her life;
c) If there is reasonable suspicion based on your report that you or anyone else (under the age of 16) may be or have been a victim of physical, sexual and/or emotional abused by anyone, the appropriate children's aid society will be informed;
d) Report a health professional who has sexually abused a client/patient;
e) Release of a client/patient file if there is a court order or summons court attendance and/or for a production of your records;
f) As part of ongoing consultation, training, education, billing or research our providers may discuss or present the particulars of your case with other health professionals or insurers related to your treatment plan. With respect to publishable research and educational purposes, any information that would enable one to identify you will be de-identified. Statutory Accident Benefit claims require disclosure of health information (resulting from the motor vehicle accident as well as pre-existing conditions) to insurers, health professionals and social workers involved in your claim. Finally, professional Colleges conduct random Quality Assurance and it is possible that patient files will be disclosed to them if they initiate this process or a similar process.

VIII. Payment Policy: Payment for assessments and therapy is normally expected at each session (Cash, VISA, MASTERCARD, Debit, etc.) unless an alternate arrangement has been made with Clinical Director (with the exception of WSIB and Motor Vehicle Insurance Claims). In this way, the account remains manageable and your therapy becomes a naturally budgeted expense. Receipts will be given when payment is received. Please retain these receipts for your insurance or income tax claims, if applicable. SPINEgroup does not guarantee supplements, orthotics, braces, or any assistive mobility device.

IX. Cancellation Policy: Payment is expected for any missed session, unless the appointment is cancelled **at least forty-eight (48) business hours** in advance. If you arrive more than twenty (20) minutes late for an appointment, you will be charged the full session fee. In accordance with the professional fees and billing practices, overdue accounts will be charged interest rates of 1.5% monthly. If payment becomes a concern, please discuss it with the clinical director or clinic manager to avoid service charges for late payment or more active efforts to secure overdue statements.

SIGNED CONSENT

☐ **I consent to disclosure of my PHI to treating health providers at SPINEgroup who are involved in my care. Your signature indicates you have reviewed our *Informed Consent & Permission to Disclose Health Information* form about the potential risks of assessments, treatments and rehabilitation; the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. You understand that, as explained herein, there are some rare exceptions to these commitments.**

☐ **I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my health provider the nature and purpose of my treatment in general, benefits and risk of treatment, alternate treatment options and recommendations for my condition, payment and cancellation policies and all the contents of this Consent. I have been given a chance to ask any questions about assessment and treatment risks and they have been answered to my satisfaction. I consent to the interdisciplinary treatment recommended to me by my provider including any recommended assessments, evaluations, rehabilitation, physical medicine, manual therapy, medical or naturopathic services and counseling services provided by any of the clinicians at SPINEgroup as listed in Section I**.

→ Email Address: ____ [optional]

☐ I further agree to receive SPINEgroup's newsletters containing news, updates and health promotions regarding SPINEgroup's health services and products. You can later withdraw your consent at any time by sending an email to info@spinegroup.ca.

☐ I also intend this Informed Consent to apply to all my present and future care at Spinegroup Health Clinic.

Date________________________________

________________________________ ________________________________

Patient Signature (Legal Guardian) **Witness/Signature**

Print Name:__________________________ **Print Name:** ______________________________

COVID-19 Notice and Screening Consent

Dear Patient:

The purpose of this form is to enhance patient safety by screening patients for symptoms of COVID-19, recent travel and any knowledge of potential exposure events. Please check each box below.

	YES	NO
I **consent** to having my temperature taken by SPINEgroup® staff.	☐	☐
Do you have any COVID-19 symptoms including: **Fever > 38°C**; **Cough**; **Sore Throat**; **Shortness of Breath**; **Difficulty Breathing**; **Flu-like symptoms**; or **Runny Nose**.	☐	☐
Have you, or anyone in your household, **travelled outside of Canada** in the last 14 days?	☐	☐
Have you, or anyone in your household, **been in contact** in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?	☐	☐
Have you **tested positive** for COVID-19?	☐	☐
Are you currently being **investigated as a possible case** of COVID-19?	☐	☐
I understand that SPINEgroup® has the **right to reschedule my appointment** if I have COVID-19 symptoms, or recently traveled outside Canada, or have been in contact with someone who is COVID-19 positive.	☐	☐

I confirm that the information I have provided on this form is truthful and accurate.

____ **SIGNATURE OF PATIENT**

Printed Patient Name: ______________________________ **Date**: ________________