Patient Name: ____________________  Patient ID: ____________________  Date: __________

Body area #1:
What was the typical level of your pain the past week? If you don’t have pain please circle zero. (Circle only one number)

Body area #2 (if applicable):
What was the typical level of your pain the past week? If you don’t have pain please circle zero. (Circle only one number)

Body area #3 (if applicable):
What was the typical level of your pain the past week? If you don’t have pain please circle zero. (Circle only one number)
The Keele STarT Back Screening Tool

Patient name: _______________________________    Date: _____________

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Very much</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Total score (all 9):</td>
<td>___________</td>
<td>Sub Score (Q5-9): ___________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Low Back Oswestry 2.1a

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

**Pain intensity**

0 I have no pain at the moment.
1 The pain is very mild at the moment.
2 The pain is moderate at the moment.
3 The pain is fairly severe at the moment.
4 The pain is very severe at the moment.
5 The pain is the worst imaginable at the moment.

**Personal care (washing, dressing, etc.)**

0 I can look after myself normally without causing extra pain.
1 I can look after myself normally but it is very painful.
2 It is painful to look after myself and I am slow and careful.
3 I need some help but manage most of my personal care.
4 I need help every day in most aspects of self care.
5 I do not get dressed, wash with difficulty and stay in bed.

**Lifting**

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it gives extra pain.
2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
4 I can lift only very light weights.
5 I cannot lift or carry anything at all.

**Walking**

0 Pain does not prevent me walking any distance.
1 Pain prevents me walking more than one mile.
2 Pain prevents me walking more than a quarter of a mile.
3 Pain prevents me walking more than 100 yards.
4 I can only walk using a stick or crutches.
5 I am in bed most of the time and have to crawl to the toilet.

**Standing**

0 I can stand as long as I want without extra pain.
1 I can stand as long as I want but it gives me extra pain.
2 Pain prevents me from standing for more than 1 hour.
3 Pain prevents me from standing for more than half an hour.
4 Pain prevents me from standing for more than 10 minutes.
5 Pain prevents me from standing at all.

**Sleeping**

0 My sleep is never disturbed by pain.
1 My sleep is occasionally disturbed by pain.
2 Because of pain I have less than 6 hours sleep.
3 Because of pain I have less than 4 hours sleep.
4 Because of pain I have less than 2 hours sleep.
5 Pain prevents me from sleeping at all.

**Sex life (if applicable)**

0 My sex life is normal and causes no extra pain.
1 My sex life is normal but causes some extra pain.
2 My sex life is nearly normal but is very painful.
3 My sex life is severely restricted by pain.
4 My sex life is nearly absent because of pain.
5 Pain prevents any sex life at all.

**Social life**

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

**Travelling**

0 I can travel anywhere without pain.
1 I can travel anywhere but it gives extra pain.
2 Pain is bad but I manage journeys over two hours.
3 Pain restricts me to journeys of less than one hour.
4 Pain restricts me to short necessary journeys under 30 minutes.
5 Pain prevents me from travelling except to receive treatment.

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Neck Pain

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

**Pain intensity**
- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate and does not vary much.
- 3 The pain is fairly severe at the moment.
- 4 The pain is severe but comes and goes.
- 5 The pain is severe and does not vary much.

**Personal care (washing, dressing, etc.)**
- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help but manage most of my personal care.
- 4 I need help every day in most aspects of self care.
- 5 I do not get dressed, wash with difficulty and stay in bed.

**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 but I can manage if they are conveniently positioned, e.g. on a table.
- 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- 4 I can lift only very light weights.
- 5 I cannot lift or carry anything at all.

**Reading**
- 0 I can read as much as I want to with no pain in my neck.
- 1 I can read as much as I want with slight pain in my neck.
- 2 I can read as much as I want with moderate pain in my neck.
- 3 I cannot read as much as I want because of moderate pain in my neck.
- 4 I cannot read as much as I want because of severe pain in my neck.
- 5 I cannot read at all.

**Headache**
- 0 I have no headaches at all.
- 1 I have slight headaches which come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have headaches almost all the time.

**Concentration**
- 0 I can concentrate fully when I want to with no difficulty.
- 1 I can concentrate fully when I want to with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating when I want to.
- 3 I have a lot of difficulty in concentrating when I want to.
- 4 I have a great deal of difficulty in concentrating when I want to.
- 5 I cannot concentrate at all.

**Work**
- 0 I can do as much work as I want to.
- 1 I can only do my usual work, but no more.
- 2 I can do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

**Driving**
- 0 I can drive my car without neck pain.
- 1 I can drive my car as long as I want with slight pain in my neck.
- 2 I can drive my car as long as I want with moderate pain in my neck.
- 3 I cannot drive my car as long as I want because of moderate pain in my neck.
- 4 I can hardly drive my car at all because of severe pain in my neck.
- 5 I have no social life because of pain.

**Sleeping**
- 0 My sleep is never disturbed by pain.
- 1 My sleep is occasionally disturbed by pain.
- 2 Because of pain I have less than 6 hours sleep.
- 3 Because of pain I have less than 4 hours sleep.
- 4 Because of pain I have less than 2 hours sleep.
- 5 Pain prevents me from sleeping at all.

**Recreation**
- 0 I am able engage in all recreational activities with no pain in my neck at all.
- 1 I am able engage in all recreational activities with some pain in my neck.
- 2 I am able engage in most, but not all recreational activities because of pain in my neck.
- 3 I am able engage in a few of my usual recreational activities because of pain in my neck.
- 4 Pain restricts me to short necessary journeys under 30 minutes.
- 5 I cannot do any recreational activities all
Patient Health Questionnaire - PHQ

Patient Name ________________________________ Date __________________

1. Describe your symptoms

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms
   (76-100% of the day)
   (51-75% of the day)
   (26-50% of the day)
   (0-25% of the day)

3. What describes the nature of your symptoms?

4. How are your symptoms changing?

5. During the past 4 weeks:
   a. Indicate the average intensity of your symptoms
   b. How much has pain interfered with your normal work (including both work outside the home, and housework)

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
   (like visiting with friends, relatives, etc)

7. In general would you say your overall health right now is...

8. Who have you seen for your symptoms?
   a. What treatment did you receive and when?
   b. What tests have you had for your symptoms and when were they performed?

9. Have you had similar symptoms in the past?
   a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?
    a. If you are not retired, a homemaker, or a student, what is your current work status?

Patient Signature ________________________________ Date __________________