Dr. Burnham & Associates
#1-6220 - Hwy 2 A, Lacombe, AB. T4L 2G5
Ph: 403 782 6555 Fx: 403 782 6511
feedback@capriclinic.ca

Patient Intake Questionnaire

Thank you for completing this questionnaire! Doing so will help us better understand your medical condition. Your responses will be held in the strictest confidence. **Please answer every question**. There is no right or wrong answer. If you are not sure how to answer a question, just give the best answer you can. You can make comments in the margin. Please bring the completed form to your appointment. Thank you.

Tell us about you. What is your:

- Name: email address:
- Age:; Height: Weight:
- Dominant hand: Right / Left
- Profession:
- Marital status:

Tell us about your pain:

- When did it start?
- How did it start?

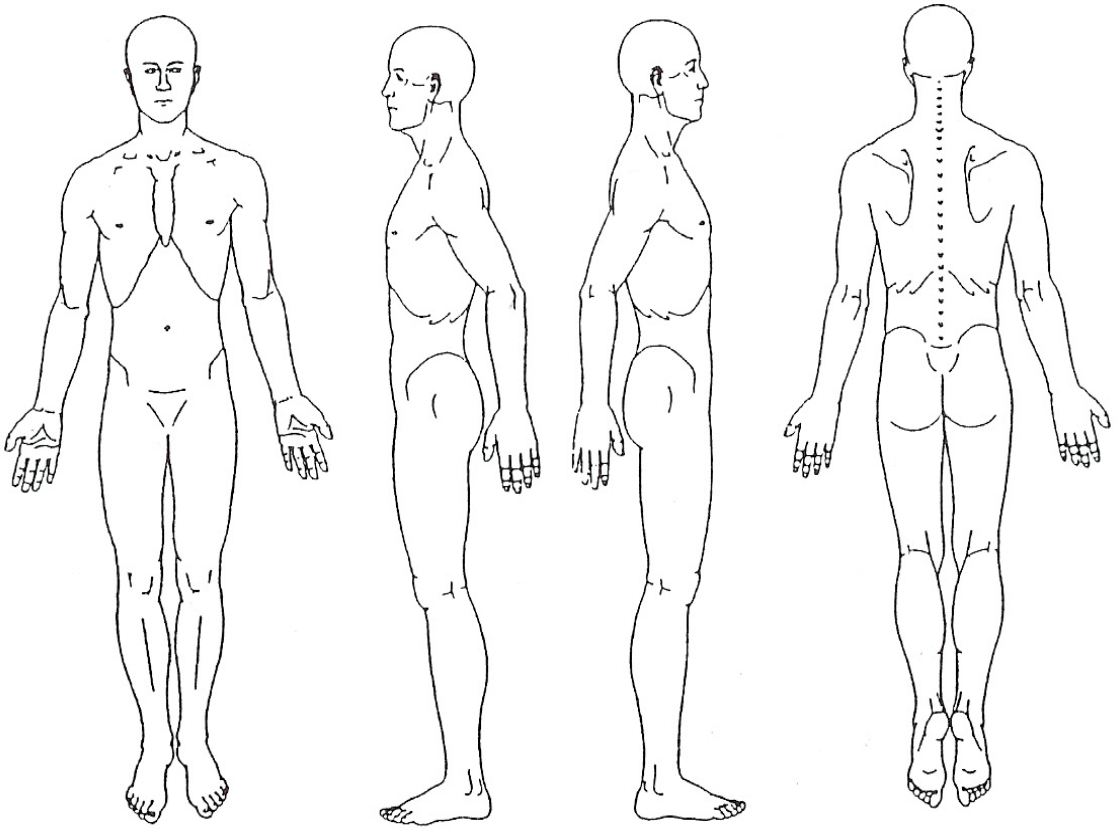
- Since it started, is it getting worse, better or staying about the same?
- Is your pain constant or does it come and go?
- Name 2 things that make your pain worse:

- Name 2 things that make your pain better:

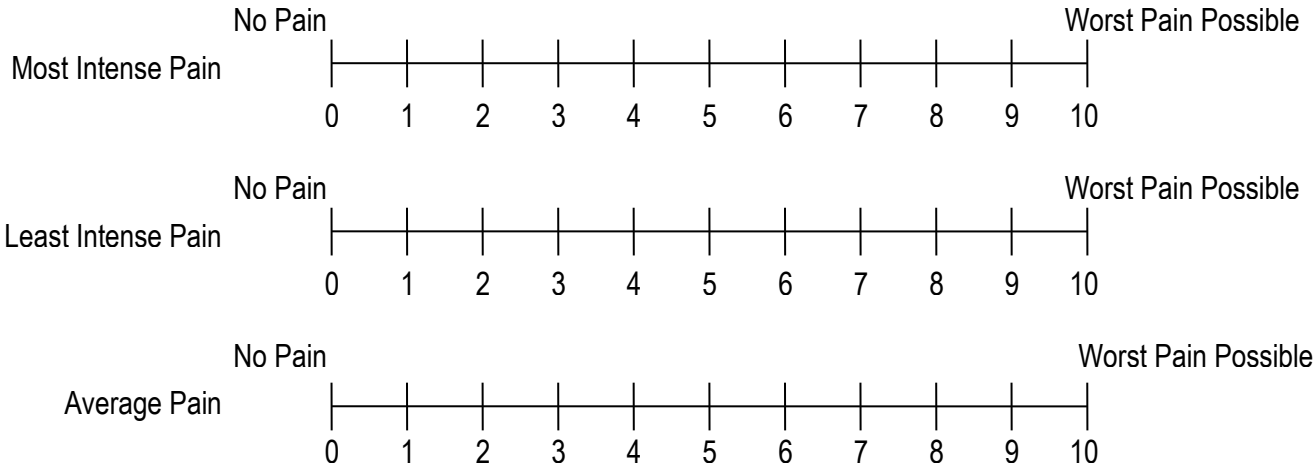
Tell us about the types of treatment you have had for your condition (i.e. physical therapy, chiropractic, massage, acupuncture, injections, surgery or other) and how you responded to each type of treatment.

Please draw the location of your symptoms on the images below. If your pain radiates, draw an arrow from where it starts to where it stops. Use the symbols listed below to further describe your pain. <u>Put a number 1 pointing to your worst area of pain.</u>

Stabbing //// Burning xxxx Aching >>>> Numbness = = = = Pins & needles 0000



Please complete the following ratings of your pain, considering how you felt <u>during the past week</u>. Place an **X** on each line representing the intensity of your **Most Intense**, **Least Intense** and **Average** pain during the past week.
0 represents ***no pain*** and 10 represent the ***worst pain possible***.



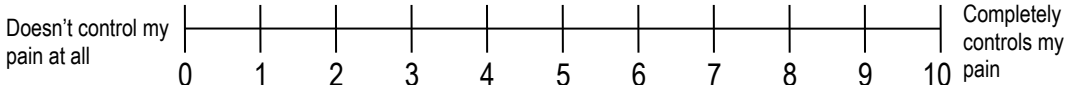
What percentage of the time are you in pain? (Please Circle)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Tell us about the medications you use.

- List the medications you currently take including the strength and dose (how many pills you take). *It would be helpful if you brought your medications to the consultation.*

Put an X on the scale below that best describes how effective your current pain medications have been over the past week:



- Have you experienced an allergic or adverse reaction to any medications? Y / N
  If yes, please list:

Tell us about your general health.

- Describe any ongoing medical conditions you have:

- List any surgeries you have had in the past:

Tell us about your family medical history.

- Do your parents or siblings have spine or chronic pain problems?

- Do any other serious medical conditions run in your family?

Tell us about your current activity level.

- Do you work outside of the home? Y / N If so, how many hours per week?

- Have you ever been off work as a result of a spine injury or condition in the past? Y / N
  If so, when and how long were you off?

- Do you participate in any fitness or exercise activities on a regular basis? Y / N
  If so, what do you do and how many times per week do you do it?

Please circle the one number that best describes how, during the past week, the <u>pain has interfered</u> with your:

A. General Activity:												
Normal activity levels	0	1	2	3	4	5	6	7	8	9	10	Can't do anything
B. Mood:												
Normal mood	0	1	2	3	4	5	6	7	8	9	10	Severely depressed
C. Walking Ability												
Normal Walking	0	1	2	3	4	5	6	7	8	9	10	Unable to walk
D. Normal Work (includes work both in an out of the home):												
Normal work load	0	1	2	3	4	5	6	7	8	9	10	Couldn't do any kind of work at all
E. Relations with other people:												
Normal interactions	0	1	2	3	4	5	6	7	8	9	10	Problems with all relationships
F. Sleep:												
Normal amounts of sleep	0	1	2	3	4	5	6	7	8	9	10	No sleep at all
G. Enjoyment of Life:												
Normal enjoyment	0	1	2	3	4	5	6	7	8	9	10	Couldn't enjoy anything at all

- Do you:
  - Smoke cigarettes? Yes / No. If yes, how much do you smoke per day?
  - Use Cannabis? Yes / No. If yes, what form do you use it and how much do you use per day?
  - Vape? Yes / No. If yes, what are you vaping and how much per day?

Tell us how your condition has affected your mood. Pick out the statement in each group that best describes how you feel today and circle the number beside the statement you have chosen. **Please complete all questions**. If a question does not describe your situation exactly, please choose the answer that is closest to how you feel.

A. Sadness
3. I am so sad or unhappy that I can't stand it
2. I am blue or sad all the time and I can't snap out of it.
1. I feel sad or blue.
0. I do not feel sad.

B. Pessimism
3. I feel that the future is hopeless and that things cannot improve.
2. I feel I have nothing to look forward to.
1. I feel discouraged about the future.
0. I am not particularly pessimistic or discouraged about the future.

C. Sense of failure
3. I feel I am a complete failure as a person.
2. As I look back on my life, all I can see is a lot of failure.
1. I feel I have failed more than the average person.
0. I do not feel like a failure.

D. Dissatisfaction
3. I am dissatisfied with everything.
2. I don't get satisfaction out of anything anymore.
1. I don't enjoy things the way I used to.
0. I am not particularly dissatisfied.

E. Guilt
3. I feel as though I am very bad or worthless.
2. I feel quite guilty.
1. I feel bad or unworthy a good part of the time.
0. I don't particularly feel guilt.

F. Self-dislike
3. I hate myself.
2. I am disgusted with myself.
1. I am disappointed in myself.
0. I don't feel disappointed in myself.

G. Self-harm
3. I would kill myself if I had the chance.
2. I have definite plans about committing suicide.
1. I feel I would be better off dead.
0. I don't have any thoughts of harming myself.

H. Social withdrawal
3. I have lost all of my interest in other people and don't care about them at all.
2. I have lost most of my interest in other people and have little feeling for them.
1. I am less interested in people than I used to be.
0. I have not lost interest in other people.

I. Indecisiveness
3. I cannot make any decisions at all anymore.
2. I have great difficulty in making decisions.
1. I try to put off making decisions.
0. I make decisions about as well as ever.

J. Self-image change
3. I feel I am ugly or repulsive looking.
2. I feel that there are permanent changes in my appearance and they make me look unattractive.
1. I am worried I am looking old or unattractive.
0. I don't feel that I look any worse than I used to.

K. Work difficulty
3. I can't do any work at all.
2. I have to push myself very hard to do anything.
1. It takes extra effort to get started at doing something.
0. I can work about as well as before.

L. Fatigability
3. I get too tired to do anything.
2. I get tired from doing anything.
1. I get tired more easily than I used to.
0. I don't get any more tired than usual.

M. Anorexia
3. I have no appetite at all anymore.
2. My appetite is much worse now.
1. My appetite is not as good as it used to be.
0. My appetite is no worse than usual.

Please check whether you *agree* or *disagree* with the following statements:

	Agree	Disagree
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 really not 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 in the last two weeks.	☐	☐
7. I feel that my back pain is terrible and that it's never going to get any better.	☐	☐
8. In general, I have not enjoyed all the things I used to enjoy.	☐	☐
9. My condition will be best managed by treatments that others provide me (massage, chiropractic, acupuncture, etc) rather than by things I can do for myself (exercise, weight loss, smoking cessation).	☐	☐
10. Overall, how bothersome has your back pain been in the last 2 weeks? Not at all ☐ Slightly ☐ Moderately ☐ Very much ☐ Extremely ☐		
11. Do you enjoy your work?	☐	☐

Please answer *yes* or *no* to the following questions:	Yes	No
A. I have stiffness in the morning which lasts more than ½ hour	☐	☐
B. I experienced dramatic pain relief when I take anti-inflammatory pills	☐	☐
C. Members of my family have ankylosing spondylitis	☐	☐
D. I have Crohn's disease or ulcerative colitis	☐	☐
E. I have had frequent recurrent inflammation in my eyes	☐	☐
F. I've had frequent problems with tendinitis	☐	☐
G. I have psoriasis	☐	☐
H. I have been diagnosed with a sexually transmitted infection in the past year. (i.e.: Gonorrhea, Chlamydia, etc.) This is relevant as they can occasionally be the cause of joint/back problems.	☐	☐

Please answer the following questions:

A. Do you experience any **unexplained** fever, chills or night sweats? Y / N Explain:

B. Have you ever been diagnosed with cancer? Y / N If yes, please explain:

C. Do you have any **CONCERNING** problems with your bowel or bladder function? Y / N If yes, please describe:

D. Over the past year, has your weight changed more than 10 lbs? Y / N How much? _____ Gain or loss?

E. Have you had a **sudden and dramatic** increase in weakness or numbness in your limbs? Y / N

F. Are you experiencing any numbness in your genital/anal area? Y / N

G. Are you on any of these medications: Prednisone Y / N Blood thinners like Coumadin or Warfarin Y / N

H. Do you have a medical condition or take medication that suppresses your immune system? Y / N