Outpatient Rehabilitation Department
Medical History Form

Name: _____ Birth Date: _____
Referring Doctor: _____ Primary Care Physician: _____
Phone Number: Home _____ Email: _____
Cell _____

Reason you are attending therapy: _____

Please check any of the following whose care you have been under (past year):
_____Medical Doctor (MD) _____ Psychiatrist/Psychologist
_____Orthopedic Doctor _____ Physical Therapy
_____Dentist _____ Chiropractor
_____Other (Explain) _____

Why have you seen the above? In addition, include any emergency room trips and prior hospitalizations. Fill in dates and Explanation below.
_____
_____
_____

If you have a history of any of the following, please indicate below:

☐ Cancer: What type?	☐ Lymes Disease
☐ Heart Problems	☐ Rheumatoid Arthritis
☐ Pacemaker	☐ Osteoarthritis
☐ High Blood Pressure	☐ Fibromyalgia Syndrome(FMS)
☐ Diabetes	☐ Depression
☐ DVT/blood clots	☐ Thyroid Problems
☐ Circulation problem	☐ Joint Replacement
☐ Osteoporosis	☐ Multiple Sclerosis
☐ Asthma	☐ Seizures
☐ Emphysema/Bronchitis	☐ Epilepsy
☐ Tuberculosis	☐ Stroke
☐ Kidney Disease	☐ Alcoholism, Illicit Drug Use
☐ HIV Disease/AIDS	☐ Hepatitis
☐ Latex Allergy	☐ Gout
☐ Other Allergies: Explain	☐ Other: Explain

During the past month, have you been feeling down, depressed or hopeless? YES NO
During the past month, have you had little interest in doing things? YES NO
Do you feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO
Date of last menstrual period: _____

Please Describe any significant injuries for which you have been treated (including fractures, sprains, etc. and the approximate date off injury.

Date	Injury	Date	Injury

Which of the following OVER-THE-COUNTER medication have you taken in the past week?

Yes	No	Aspirin
Yes	No	Tylenol
Yes	No	Advil/Motrin/Ibuprofen
Yes	No	Laxatives
Yes	No	Decongestant
Yes	No	Antihistamines
Yes	No	Antacid
Yes	No	Vitamins/Mineral supplement
Yes	No	Other

Please list any PRESCRIPTION medication you are currently taking (INCLUDING tablets, capsules, patches, and/or injections).

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

How many caffeinated coffee or caffeine containing beverages do you drink per day? _____
Do you smoke? Yes ____ No ____
If you do smoke, how many cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ___

Have you recently noted:

Yes	No	Unexplained weight loss or weight gain
Yes	No	Nausea/Vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/chills/sweats
Yes	No	Numbness/tingling
Yes	No	Dizziness when you stand up
Yes	No	Chest pain
Yes	No	Shortness of breath

Patient signature_____ Date_____

Therapist Signature _____ Date_____

Hackensack UMC Mountainside

1 Bay Avenue
Montclair, NJ 07042

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our highly qualified and motivated staff is here to make your rehabilitation experience beneficial as well as enjoyable. To ensure this, we are providing some simple guidelines to follow:

- Please double check with your insurance company to make sure that we do participate with your plan. Ultimately, you are responsible for any financial obligations that are associated with your insurance.
- If your insurance requires a pre-certification there may be delay in your follow up visit. The rehabilitation department will notify you when the authorization is received.
- If you have a Co-payment, it is required prior to services being rendered.
- If you accumulate three no shows or cancelled appointments you will may discharged for the services you are receiving at the Outpatient Department of Hackensack UMC Mountainside. You will not be permitted to schedule future appointment at this facility without written consent from the Director of Rehabilitation Services.
- Please be prompt with your scheduled appointment so we can maximize your treatment. If you are arriving late, your treatment time is subject to cancellation and rescheduling.
- Please bring or wear proper clothing to make you affected treatment area accessible. We do provide changing rooms with lockers for you convenience.(Please bring your own lock)
- In case of inclement weather, please call ahead of time to confirm your appointment.
- Use of cellular phones is prohibited inside the gym area. Please turn off your cellular phone when you are inside of the gym.
- Anyone who is under the age of 18 in the reception/waiting area unattended. Please make arrangement for your children before coming to Physical Therapy.
- Most importantly, please communicate with your therapist! The more information that is known the better we can help you recover.

By following these simple guidelines, together we can reach your goal in the shortest amount of time.
Thank you again for choosing us as your rehabilitation provider.

Please sign to acknowledge that you have read and understood the guidelines.

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

Hackensack UMC Mountainside
1 Bay Avenue
Montclair, NJ 07042

Insurance Authorization/Pre-certification information

Welcome to the Rehabilitation Department at Hackensack UMC Mountainside. Our staff will make every effort to work with you and your insurance company. However, the following conditions apply:

- Please be advised that some insurance companies require pre-certification/ authorization before starting any physical therapy treatment
- Please follow up with your insurance company to confirm whether you are required to obtain a pre-certification/ authorization
- Please inform your insurance company that all authorizations must be faxed to the Hackensack UMC Mountainside Rehabilitation Department at the following fax number 973-680-7917
- The authorization should include the amount of visits approved by your insurance company and the date span for the visits along with an authorization number
- Pre-certification/ authorization may delay your follow up appointment. To avoid a longer waiting period please contact your insurance company to expedite approval
- After your initial evaluation a member of our staff will fax the appropriate documentation to your insurance company for approval
- You are ultimately responsible for the follow up and ensure that authorization has been granted before starting treatments
- Failure to obtain an authorization from your insurance company will result in you being personally responsible for any financial obligations that are associated with your treatments

By following these guidelines and working together we hope to ensure a positive experience at Hackensack UMC Mountainside. Thank you again for choosing us as your rehabilitation provider!

_____ _____
Patient Signature Date

_____ _____
Signature of legal Guardian-Health Care Agent, or other personal Representative Date

_____ _____
Witness Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

FEAR AVOIDANCE BELIEFS QUESTIONNAIRE (FABQ)

Purpose: The FABQ was developed by Waddell to investigate fear-avoidance beliefs among LBP patients in the clinical setting.[3] This survey can help predict those that have a high pain avoidance behavior. Clinically, these people may need to be supervised more than those that confront their pain.

Scoring: The FABQ consists of 2 subscales, which are reflected in the division of the outcome form into 2 separate sections. The first subscale (items 1-5) is the Physical Activity subscale (FABQPA), and the second subscale (items 6-16) is the Work subscale (FABQW). Interestingly, not all items contribute to the score for each subscale; however the patient should still complete all items as these items were included when the reliability and validity of the scale was initially established. A low FABQW score (less than 19) was one of 5 variables in a clinical prediction rule that increased the probability of success from SI region manipulation in individuals with low back pain.[1] Each subscale is graded separately by summing the responses respective scale items (0 – 6 for each item); for scoring purposes, only 4 of the physical activity scale items are scored (24 possible points) and only 7 of the work items (42 possible points). The method to score each subscale is outlined below. (Note: It is extremely important to ensure all items are completed, as there is no procedure to adjust for incomplete items.)

Scoring the Physical Activity subscale (FABQPA)
Sum items 2, 3, 4, and 5 (the score circled by the patient for these items).

Scoring the Work subscale (FABQW)
Sum items 6, 7, 9, 10, 11, 12, and 15.

Measurement Characteristics: The FABQ has been demonstrated to be valid and reliable in a chronic LBP population[3] and appears to be a useful screening tool for identifying acute LBP patients who will not return to work by 4wks.[2]

References:

1. Flynn T, Fritz J, Whitman J, Wainner R, et al. Clinical Prediction Rule for Classifying Patients with Low Back Pain Likely to Respond to a Manipulation Technique. Spine (In Press) 2002.
2. Fritz JM, George SZ, Delitto A. The role of fear-avoidance beliefs in acute low back pain: relationships with current and future disability and work status. Pain 2001; 94:7-15.
3. Waddell G, Newton M, Henderson I, Somerville D, Main CJ. A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability. Pain 1993; 52:157-168

Name: _____ Date: _____

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
1. My pain was caused by physical activity	0	1	2	3	4	5	6
2. Physical activity makes my pain worse	0	1	2	3	4	5	6
3. Physical activity might harm my back	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain.

	COMPLETELY DISAGREE			UNSURE			COMPLETELY AGREE
6. My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
7. My work aggravated my pain	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain	0	1	2	3	4	5	6
9. My work is too heavy for me	0	1	2	3	4	5	6
10. My work makes or would make my pain worse	0	1	2	3	4	5	6
11. My work might harm my back	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to that work	0	1	2	3	4	5	6

CUESTIONARIO FAB

Aquí están algunas cosas que otros pacientes nos han dicho sobre su dolor. Por favor, para cada afirmación haga un círculo en un número del 0 al 6 para indicar hasta qué punto las actividades físicas tales como inclinarse, levantar peso, caminar o conducir afectan o afectarían a *su* dolor de espalda.

	En total desacuerdo			Ni de acuerdo ni en desacuerdo			Completamente de acuerdo
1. Mi dolor fue causado por la actividad física	0	1	2	3	4	5	6
2. La actividad física hace que mi dolor empeore	0	1	2	3	4	5	6
3. La actividad física podría dañar mi espalda	0	1	2	3	4	5	6
4. No debería hacer las actividades físicas que empeoran mi dolor, ni las que podrían empeorarlo	0	1	2	3	4	5	6
5. No puedo realizar las actividades físicas que empeoran mi dolor, ni las que podrían empeorarlo.	0	1	2	3	4	5	6

Las siguientes afirmaciones se refieren a cómo su trabajo normal afecta o afectaría a su dolor de espalda.

	En total desacuerdo			Ni de acuerdo ni en desacuerdo			Completamente de acuerdo
6. Mi dolor se debe a mi trabajo, o a un accidente en el trabajo	0	1	2	3	4	5	6
7. Mi trabajo agravó mi dolor	0	1	2	3	4	5	6
8. Estoy recibiendo o tramitando algún tipo de compensación por mi dolor de espalda, como una baja laboral, una pensión o una indemnización de cualquier tipo	0	1	2	3	4	5	6
9. Mi trabajo es demasiado pesado para mí	0	1	2	3	4	5	6
10. Mi trabajo empeora mi dolor, o podría empeorarlo	0	1	2	3	4	5	6
11. Mi trabajo puede dañar mi espalda	0	1	2	3	4	5	6
12. Con mi dolor actual, no debería hacer mi trabajo normal	0	1	2	3	4	5	6
13. Con mi dolor actual, no puedo hacer mi trabajo normal	0	1	2	3	4	5	6
14. No podré hacer mi trabajo normal hasta que mi dolor haya sido tratado	0	1	2	3	4	5	6
15. No creo que pueda regresar a mi trabajo habitual en los próximos 3 meses	0	1	2	3	4	5	6
16. No creo que sea capaz de volver nunca a mi trabajo habitual.	0	1	2	3	4	5	6

Modified Oswestry Low Back pain Disability Questionnaire

Name _____

DOB _____

Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. MARK ONE BOX in each section that most closely describes you TODAY.

Section 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.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself 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 everyday in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 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.

Section 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 ½ mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can walk only with a stick or crutches.
- ☐ 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 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 more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 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 of sleep.
- ☐ Because of pain I have less than 4 hours of sleep.
- ☐ Because of pain I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – 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 activities, but pain prevents me from performing more physically stressful activities 9i.e. lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from dong even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Section 9 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social 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. sports, etc.
- ☐ 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.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journey over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

INDICE DE LA ESPALDA

Nombre del Paciente _____ Fecha _____

Este questionario le dará información a su proveedor de salud sobre como la condición de su espalda afecta su vida diaria. Por favor conteste cada sección marcándo la frase que aplica a su condición. Si dos o más frases in una sección describen su condición, por favor marque la frase que describe su condición con más exactitud.

Intensidad del Dolor

0. El dolor va y viene y es muy suave.
1. El dolor es suave y no varía mucho.
2. El dolor va y viene y es moderado.
3. El dolor es moderado y no varía mucho.
4. El dolor va y viene y es muy severo.
5. El dolor es muy severo y no varía mucho.

Al Dormir

0. No tengo dolor cuando estoy acostado.
1. Tengo dolor cuando estoy acostado pero no evita que duerma bien.
2. Debido al dolor, mi sueño normal se ha reducido menos del 25%.
3. Debido al dolor, mi sueño normal se ha reducido menos del 50%.
4. Debido al dolor, mi sueño normal se ha reducido menos del 75%.
5. El dolor no me deja dormir.

Al Sentarse

0. Puedo sentarme en cualquier silla por tanto tiempo como quiera.
1. Puedo sentarme solamente en mi silla favorita por tanto tiempo como quiera.
2. El dolor no me permite sentarme por más de una hora.
3. El dolor no me permite sentarme por más de media hora.
4. El dolor no me permite sentarme por más de 10 minutos.
5. Evito sentarme porque ésto aumenta el dolor inmediatamente.

Al Estar De Pie

0. Puedo estar parado por tanto tiempo como quiera sin dolor.
1. Tengo algún dolor mientras que estoy parado pero el dolor no aumenta con el tiempo.
2. No puedo estar parado por más de una hora sin que el dolor aumente.
3. No puedo estar parado por más de media hora sin que el dolor aumente.
4. No puedo estar parado por más de 10 minutos sin que el dolor aumente.
5. Evito estar parado porque ésto incrementa el dolor inmediatamente.

Al Caminar

0. No tengo dolor mientras que camino.
1. Tengo algún dolor mientras que camino pero el dolor no aumenta con la distancia.
2. No puedo caminar más de una milla sin que el dolor aumente.
3. No puedo caminar más de media milla sin que el dolor aumente.
4. No puedo caminar más de un cuarto de milla sin que el dolor aumente.
5. No puedo caminar sin que el dolor aumente.

Cuidado Personal

0. No tengo que cambiar mi manera de bañarme o vestirme para evitar el dolor.
1. No he cambiado mi manera de bañarme o vestirme aunque ésto causa algo de dolor.
2. El bañarse o vestirse incrementa el dolor pero no he cambiado mi manera de hacerlo.
3. El bañarse o vestirse incrementa el dolor pero me ha sido necesario cambiar mi manera de hacerlo.
4. Debido al dolor, no puedo hacer alguna parte de mi baño o vestido sin ayuda.
5. Debido al dolor, no puedo bañarme o vestirme sin ayuda.

Al Levantar Objetos

0. Puedo levantar objetos pesados sin que cause más dolor.
1. Puedo levantar objetos pesados pero ésto causa más dolor.
2. El dolor no me permite levantar objetos pesados del piso.
3. El dolor no me permite levantar objetos pesados del piso, pero puedo levantarlos si son convenientemente colocados (por ejemplo, en una mesa).
4. El dolor no me permite levantar objetos pesados del piso, pero puedo levantar objetos livianos o medianamente pesados si son colocados convenientemente.
5. Puedo levantar solamente objetos muy ligeros.

Al Viajar

0. No tengo dolor al viajar.
1. Tengo algo de dolor al viajar pero ninguna de mis maneras habituales de viajar empeoran el dolor.
2. Tengo más dolor al viajar pero ésto no me obliga a buscar otras formas de viajar.
3. Tengo más dolor al viajar lo que me obliga a buscar otras formas de viajar.
4. El dolor ha restringido todas las formas de viaje excepto cuando voy acostado.
5. El dolor ha restringido todas las formas de viaje.

Vida Social

0. Mi vida social es normal y no me causa más dolor.
1. Mi vida social es normal pero aumenta el dolor.
2. El dolor no ha tenido un efecto significante en mi vida social aparte de limitar mis intereses más enérgicos (por ejemplo, bailar, etc).
3. El dolor ha restringido mi vida social y no salgo muy frecuentemente.
4. El dolor has restringido mi vida social a mi casa.
5. Difícilmente tengo alguna vida social debido al dolor.

Cambio en el Grado de Dolor

0. Mi dolor esta mejorando rápidamente.
1. Mi dolor fluctúa pero está mejorando definitivamente.
2. Mi dolor parece estar mejorando pero la mejoría es lenta.
3. Mi dolor no está ni mejorando ni empeorando.
4. Mi dolor está empeorando gradualmente.
5. Mi dolor está empeorando rápidamente.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score_____