

Spinal Clinic

Printable version of paperwork

Please print off and complete all 4 pages and bring with you to one of the spinal clinic, times / locations below.

Your clinical information will be assessed. You will be allocated an appointment which may not be on the same day

- Page 1 – Name / address / contact details / body chart / symptoms / medication
- Page 2 – Spinal Questionnaire
- Page 3 – Patient Specific Functional Index
- Page 4 – The Keele STarT Back Screening Tool

**If you have any questions or queries please contact any of our sites
 Mon – Fri 8.30 am – 4.30 pm, closed weekends, bank and public holidays.**

Physiotherapy Sites	Spinal Drop-In Dates and times
Barbara Castle Way Health Centre Simmons St, Blackburn, BB2 1AX Tel: 01254 736111 / 736112	Monday 8.30 am – 2.30 pm NB: Strict time limits to parking. If possible, please find alternative parking as fines could be imposed.
Darwen Health Centre James Street West, Darwen, BB3 1PY Tel: 01254 736121	Wednesday 8.15 am – 2.00 pm
Burnley General Hospital Casterton Avenue, Burnley, BB10 2PQ Tel: 01282 803294	Monday 12.15 pm – 2.15 pm
St Peter's Primary Health Care Centre Church St, Burnley, BB11 2DL Tel: 01282 805570 / 803294	Thursday 8.00 am – 12.00 pm
Pendle Community Hospital Leeds Road, Nelson, BB9 9SZ Tel: 01282 804983	Tuesday 8.30 am – 10.30 am Thursday 12.30 pm - 2.45 pm
Rosendale Primary Health Care Centre Bacup Road, Rawtenstall, BB4 7PL Tel: 01706 235398	Wednesday 8.45 am – 2.30 pm
Accrington Pals Health Centre 1 Paradise Street, Accrington, BB5 2EJ Tel: 01254 736018	Tuesday 8.45 am– 11.00 am Thursday 12.30 pm – 2.45 pm
Clitheroe Community Hospital Chatburn Road, Clitheroe, BB7 4JX Tel: 01200 449030	Monday 1.45 pm – 4.15 pm Thursday 8.15 am – 10.30 am

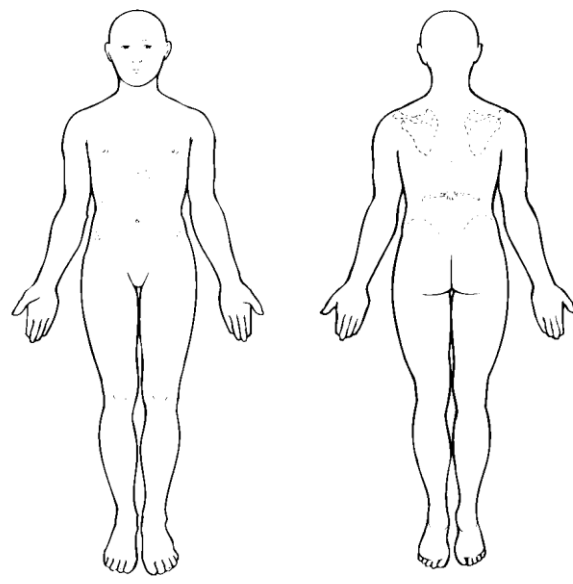
NHS number: _____ EMIS number: _____
 STaRT Back Score: Low / Medium / High Safer Handling Risk: Low / Medium / High

Mr Mrs Miss Ms Other: _____ Gender: Male Female Other: _____
 Forename(s): _____ Surname: _____
 Preferred name: *(the name by which you would like our staff to address you by)* Previous surname: _____
 Date of Birth: _____ Age: _____
 Address: _____ Home telephone: _____
 Mobile telephone: _____
 Daytime contact number: *(if different to above)* _____
 Post Code: _____ Can we leave a message on your answer phone?
 Email: _____ Yes Home / Mobile / Work
 No No answer phone available

Name of your GP/Doctor _____ Surgery _____

We require your permission / consent to view your shared medical records? *(For e.g. held by your GP surgery / hospital to help with your care and treatment)*. Yes I give consent No I do not give consent

Please indicate on the body chart below your symptoms: Include: Pain / pins and needles / numbness



How long have you had these symptoms?

Describe your symptoms?

Is this problem preventing you from working? If so for how long?

Current medication for this problem?

Patient signature: _____ Date: _____

Spinal Clinic Questionnaire 2 (Please ensure all questions are answered)

Name: Date of Birth:

Please tick the appropriate box for your answer

1. Have your symptoms started as a result of an injury?
Yes No

If yes, please specify the date and nature of the injury:
.....

2. Have you used steroid tablets for longer than 3 months?
Yes No

3. Have you had any unexplained weight loss since the onset of your symptoms?
Yes No

4. Are you experiencing any of the following symptoms?
Difficulties with your bladder, bowel or sexual function **since the onset of your symptoms**,
e.g. altered toilet habits?
Yes No

Loss of feeling in the genital or anal region **since the onset of your symptoms**
Yes No

5. Have you had an infection in the last 3 months?
If yes, please specify:
.....

6. Please tick the box if you have a history of any of the following conditions.

Osteoporosis

Epilepsy

Cancer

7. Have you had any treatment / intervention for this problem before? Or are you currently under any other service for this problem?

8. Have you had any recent investigations for this problem e.g. blood tests / x-ray / scan?

Patient Specific Functional Scale (Spinal Clinic Questionnaire 3)

Name: _____ Date of Birth: _____

To help us work with you to set goals and targets for your episode of care within the physiotherapy service could we ask you to complete the following:

Patient Specific Functional Scale (PSFS)

Please think of two or more important activities that you are unable to do or are having difficulty with **because of the problem you have come to see us about**.

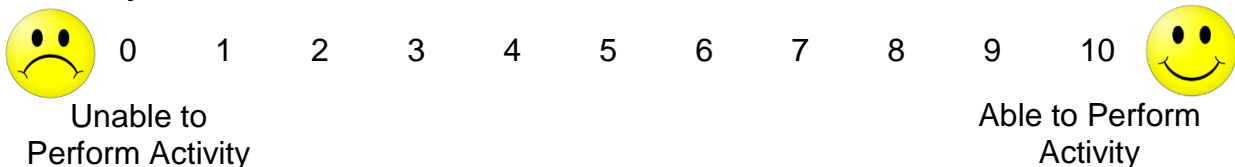
Please write the activities where indicated and then circle the number that is closest to your ability to carry out that activity today.

Unable to perform activity = 0  Able to perform activity = 10 

Activity One: _____



Activity Two: _____



The Keele STarT Back Screening Tool (Spinal Clinic Questionnaire 4)

Name: _____ Date of Birth: _____

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

	Disagree 0	Agree 1			
1. My pain had spread in the last 2 weeks.	<input type="checkbox"/>	<input type="checkbox"/>			
2. In addition to my main pain, I have had pain elsewhere in the last two weeks.	<input type="checkbox"/>	<input type="checkbox"/>			
3. In the last 2 weeks, I have only walked short distances because of my pain.	<input type="checkbox"/>	<input type="checkbox"/>			
4. In the last 2 weeks, I have dressed more slowly than usual because of pain.	<input type="checkbox"/>	<input type="checkbox"/>			
5. It is not really safe for a person with a condition like mine to be physically active.	<input type="checkbox"/>	<input type="checkbox"/>			
6. Worrying thoughts have been going through my mind a lot of the time in the last 2 weeks.	<input type="checkbox"/>	<input type="checkbox"/>			
7. I feel that my pain is terrible and it's never going to get any better .	<input type="checkbox"/>	<input type="checkbox"/>			
8. In general in the last 2 weeks I have not enjoyed all the things I used to enjoy.	<input type="checkbox"/>	<input type="checkbox"/>			
Overall, how bothersome has your pain been in the last 2 weeks .					
9.	Not at all 0	Slightly 0	Moderately 0	Very Much 1	Extremely 1
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Distress sub-scale

Total score (all 9): . . . Sub-score (Q5-9) . . . Low / Medium / High

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