

Back Pain Management Programme

Self Assessment Form

You have been referred for an assessment for the back pain management programme. The programme is for three weeks (Monday to Thursday, 09:30 – 15:30). It aims to reduce the disability and distress caused by your chronic pain and to improve your quality of life. These aims are achieved by teaching physical, psychological and practical techniques which will help you cope better with the pain and enable you to improve your level of fitness.

We aim to help you work towards specific goals that you will define and for you to be in control of your pain.

You will also carry out a graded exercise programme in the gym followed by hydrotherapy. It is important to note there is no 'hands on' physical treatment during the programme.

If you have any problems with the questions or need any help, we can go through this at the assessment. Thank you for your co-operation.

What would you like to achieve from attending the programme?

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Who have you consulted about your back pain?

- | | | | |
|----------------|--------------------------|------------------------|--------------------------|
| GP | <input type="checkbox"/> | Spinal Physiotherapist | <input type="checkbox"/> |
| Pain Clinic | <input type="checkbox"/> | Neurosurgeon | <input type="checkbox"/> |
| Rheumatologist | <input type="checkbox"/> | | |

Other (please state)

What treatments have you had?

- | | | | |
|------------------------|--------------------------|---------------------|--------------------------|
| Physiotherapy | <input type="checkbox"/> | Psychotherapy | <input type="checkbox"/> |
| Hydrotherapy | <input type="checkbox"/> | Counselling | <input type="checkbox"/> |
| TENS | <input type="checkbox"/> | Acupuncture | <input type="checkbox"/> |
| Medication | <input type="checkbox"/> | Injections | <input type="checkbox"/> |
| Occupational Therapy | <input type="checkbox"/> | Osteopath treatment | <input type="checkbox"/> |
| Chiropractor treatment | <input type="checkbox"/> | | |

Other treatment (please state):

Current/Past health problems? Please tick the relevant boxes below.

- | | | | |
|---------------------------|--------------------------|--------------|--------------------------|
| Arthritis/Joint Pain | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Heart Condition | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |
| Asthma/breathing problems | <input type="checkbox"/> | | |
- Other conditions (please state):
-
-

Hydrotherapy Contraindications:

- | | | | |
|-------------------------|--------------------------|----------------------------|--------------------------|
| Chlorine allergy | <input type="checkbox"/> | Unstable angina | <input type="checkbox"/> |
| Short of breath at rest | <input type="checkbox"/> | Short of breath lying down | <input type="checkbox"/> |
| Incontinence | <input type="checkbox"/> | Uncontrolled heart failure | <input type="checkbox"/> |

What medications are you currently taking (including dosages if known)?

Medication

Dosage

- | | |
|---------------|--------------------------|
| Amitriptyline | <input type="checkbox"/> |
| Gabapentin | <input type="checkbox"/> |
| Pregabalin | <input type="checkbox"/> |
| Tramadol | <input type="checkbox"/> |
| Paracetamol | <input type="checkbox"/> |
| Ibuprofen | <input type="checkbox"/> |
| Co-codamol | <input type="checkbox"/> |
| Meptid | <input type="checkbox"/> |
| Voltarol | <input type="checkbox"/> |

Other:

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Do you do any form of exercise? Y/N

If so what? (such as walking, cycling, gym, exercises class, swimming, wii-fit)

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Thank you for taking the time to fill out this questionnaire. This information is to help us provide the best care for you and will be held in your medical records.