MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Phone. (763)595-3200 | Fax (763) 595-3333

The STarT Back Musculoskeletal Screening Tool

Patient name: ______________________ Date: __________

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

		Disagree 0	Agree 1
1	My pain has **spread** at some time in the past 2 weeks	☐	☐
2	In addition to my main pain, I have had **pain elsewhere** in the last 2 weeks	☐	☐
3	In the last 2 weeks, I have only **walked short distances** because of my pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my 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 2 weeks	☐	☐
7	I feel that **my pain is terrible** and that **it's never going to get any better**	☐	☐
8	In general in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy	☐	☐

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

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Originally developed by:
© Keele University 01/08/07
Funded by Arthritis Research UK

American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9077

INITIAL HEALTH STATUS

PT OT ST AT Fax: 877.248.2746

Patient Name________________________ Subscriber ID #________________ Primary Language________

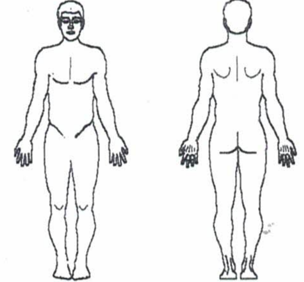
Describe Your Current Problem and How It Began____

____

____

Onset date/Surgery date____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?
☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:
☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?
☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken________________________ **What areas were taken?**________________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)________________________
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)________________________
____
☐ Osteoporosis
☐ Other Health Problems (Explain)________________________
____

☐ Numbness (Location)________________________
☐ Urinary Problems
☐ Currently Pregnant, # Weeks________________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries________________________
____
☐ Tobacco Use - Type________________________
Frequency________________________/Day
☐ Current Medications________________________
____

Who have you seen for your condition before today? ☐ No One
☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other________________________
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?____

What is your occupation?____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature________________________________ **Date**________________