Guidelines for spinal form completion (Jan 2020)

History: ***Patient responses are recorded but supplemented by the clinician as appropriate***	
Referral:	Circle the appropriate, may record date of follow-up appointment.
Work demands / leisure activities:	**Work demands**: Record work activities and indicate frequency of activity e.g. 50% sitting, 50% standing. Other types of stresses can also be noted e.g. pressure from deadlines **Leisure activities:** Record leisure or hobby activities and indicate frequency of activity e.g.; 75% sitting, 25% bending or could say walking 3 x week 40 mins, gardening 3 hours/week for example. Can note activity level in general e.g. 'sedentary' or 'very active'
Functional limitation for present episode:	Ask patient to identify specific activities that they are unable to perform or have difficulty performing because of their current symptoms.
Outcome / screening score:	Record the specific outcome measure or screening tool being used, and the score.
NPRS Score:	Ask the patient the intensity of their pain, include the intensity of the most distal. Can use a pain range, or use the average intensity of pain.
Body Chart:	Used to record "all symptoms this episode" i.e. all the symptoms the patient has experienced this episode. All symptoms may not still be present.
Present Symptoms:	Record the location/type of symptoms that are still concerning the patient. This may differ from the body chart as not all may still be present. Timeframe can be noted e.g. back pain only in last 48 hours
Present Since:	Usually given in weeks or days. Can write a specific date if known or if needed for legal reasons.
Improving / Unchanging / Worsening:	Circle as appropriate, and ask patient how, or in what way their symptoms are improving or worsening.
Commenced as a Result of:	If appropriate describe mechanism of injury e.g. lifting and twisting Or circle 'no apparent reason'.
Symptoms at Onset:	Circle the time frame of onset of initial pain e.g. circle "back", then record onset of other symptoms.
Constant / Intermittent:	Circle as appropriate. Back = to gluteal fold, Thigh = above knee, Leg = below knee, Neck = to tip of shoulder, Arm = shoulder to elbow, Forearm = forearm to hand.
Better / Worse Section:	Recording

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	Circle for always – if not clarified this means immediate pain response. If relates to time need to clarify outside the circle with e.g. 10minutes, prolonged. *Line under* – sometimes. *Oblique line through* – no effect. Put a ? above activity if patient still unsure even after further questions, rather than leave blank. If patient presents with two unrelated areas of symptoms, indicate which activities affect which symptom.
Disturbed Sleep:	If always circle Yes, sometimes underline Yes. Not affected circle No. If was previously circle Yes but write "previously".
Sleeping Postures:	Circle usual, indicate if unable to use this because of current pain and indicate present position – best and worse.
Surface / pillows:	Note surface (for lumbar) and pillow number and type (for cervical) if appears relevant.
Previous spinal history:	Write if episodic, document previous location of symptoms, length of previous episodes, severity of episodes, and if symptom free between episodes.
Previous treatments:	Record what treatments they have had for this episode and, if appropriate, what treatments they have had for previous episodes. Indicate if anything has previously helped.
Specific Questions:	Circle appropriate answers and write any clarifications on the lines provided.

Physical Examination:	
It is not essential to perform all components of the Physical examination with every patient. If any section is not performed an oblique line is drawn through it.	
Postural Observation:	Circle appropriate response.
Change of Posture:	Circle response and indicate which pain changes and to which posture change, if appropriate.
Other Observations / functional baselines	Record any significant observations e.g. wasting, swelling, redness etc. Note relevant functional baselines e.g. reaching, squatting.
Neurological Examination:	Qualify which deficit in each section, recorded if abnormal, e.g. decreased S1 reflex. Can add Babinski / Clonus to reflexes if required. Record as "normal" if testing was normal. Oblique line through if not applicable

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Physical Examination:	
Movement Loss:	The boxes Maj/Mod/Min/Nil can be used as a line i.e. more as a continuum. Can also record if symptoms or 'stiffness' is limiting movement in 'symptom' box, if patient is reporting pain, indicate location of the pain.
Test Movements:	If the order of the test movement is performed differently to that on the form, number the order. Can also record the total number of repetitions performed **Symptomatic response** - Use standard terms only. Monitor and describe effect on all symptoms, especially the most distal. **Mechanical response** – put up or downward arrow in appropriate box. Can indicate which movement has been affected by the change if it is different to the one being tested.
Static Tests:	Circle the position performed in and record with standard "After" words.
Other Tests:	State which tests and the response achieved.
Provisional Classification:	Circle the classification. For Derangement, record the pain location and the Directional Preference. For Dysfunction, record the direction. For OTHER, record the sub-group. Circle any relevant drivers of pain and disability and note details on the line below
Principle of Management:	**Education** - Record specifics, e.g. posture change, temporary avoidance of flexion, reassurance etc. **Exercise Type** - Document the specific exercises provided to the patient. e.g. RFIL, and note **Frequency** Document any other exercises or interventions given **Management Goals** – Indicate what you expect to change by next visit and things you wish to reassess on Day 2. The patient's short and long term goals can be recorded also.