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**NEW PATIENT FORMATION**

Name:

(Last) (First) (Middle)

Address: City: State: Zip:

Home Phone: Cell Phone: Drivers License:

**E-mail: \*Preferred contact method:**  **Phone**  **Text**  **Email**

Birth Date: SSN: Sex:  Male  Female Age: Marital Status:  Single  Married  Partnered  Divorced  Widowed

Race:  American Indian / Alaska Native  Asian  Pacific Islander  White  Hispanic

Black / African American  Other Unknown Decline

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tobacco Use: NEVER / PREVIOUSLY BUT QUIT / YES Packs/Day: \_\_\_\_\_\_\_

Employed / Unemployed / Disabled / Retired Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If employed: Hours/Week \_\_\_\_\_\_ Labor Type: HEAVY / MODERATE / SEDENTARY

(construction) (desk)

If disabled: Are you receiving Social Security Disability (SSDI): YES / NO

Are you receiving Workers’ Compensation: YES / NO

History of spine injections: Lumbar / Thoracic / Cervical / None / Unsure of location

SURGICAL HISTORY (including Injections): (List Procedure and Date)

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PLEASE LIST YOUR MEDICATIONS INCLUDING DOSAGE AND FREQUENCY HERE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Oswestry Low Back Pain Disability Questionnaire**

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just mark the spot that indicates the statement which most clearly describes your problem.

**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 normally without causing extra pain ⎕I can look after myself normally but it causes extra pain ⎕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 dress, I wash with difficulty and stay in bed

**Section 3 -- Lifting**

⎕I can lift heavy weight 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 places (eg. on a table) ⎕Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned ⎕I can lift heavy weights ⎕I cannot lift or carry anything at all

**Section 4 -- Walking**

⎕Pain does not prevent me from walking any distance ⎕Pain prevents me from walking more than 1 mile ⎕Pain prevents me from walking more than ½ mile ⎕Pain prevents me from walking more than 100 yards ⎕I can only walk using a stick or crutches ⎕I am in bed most of the time

**Section 5 -- Sitting**

⎕I can sit in any chair for as long as I like ⎕I can only sit in my favorite chair for as long as I like ⎕Pain prevents me from sitting more than 1 hour ⎕Pain prevents me from sitting more than 30 minutes ⎕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 more than 30 minutes ⎕Pain prevents me from standing 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 pain ⎕Pain prevents me from sleeping at all

**Section 8 -- Sex life (if applicable)**

⎕My sex life is normal and causes no extra pain ⎕My sex life is normal but causes some extra pain ⎕My sex life is normal but is very painful ⎕My sex life is severely restricted by pain ⎕My sex life is nearly absent because of pain ⎕Pain prevents any sex life at all

**Section 9 -- Social life**

⎕My social life is normal and gives me no extra pain ⎕My social life is normal but increases the degree of pain ⎕Pain has no significant effect on my social life apart from limiting my more energetic interests (eg. sports) ⎕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 me extra pain ⎕Pain is bad but I manage journeys over two hours ⎕Pain restricted 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

**Numerical Rating Scale – Back/Leg**

This questionnaire has been designed to give the doctor information as to how much back and leg pain you are having right now. For each of the 3 sections below, place an X on the number at the point that best reflects how much pain you are having right now.

Back Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible

Pain

Right Leg Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible Pain

Left Leg Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible Pain

**Neck Disability Index Questionnaire**

This questionnaire has been designed to give us information as to how your neck pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just mark the spot that indicates the statement which most clearly describes your problem.

**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 normally without causing extra pain ⎕I can look after myself normally but it causes extra pain ⎕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 dress, I wash with difficulty and stay in bed

**Section 3 -- Lifting**

⎕I can lift heavy weight 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 places (eg. on a table) ⎕Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned ⎕I can lift heavy weights ⎕I cannot lift or carry anything at all

**Section 4 -- Reading**

⎕I can read as much as I want to with no pain in my neck ⎕ I can read as much as I want to with slight pain in my neck ⎕ I can read as much as I want to with moderate pain in my neck ⎕ I can’t read as much as I want because of moderate pain in my neck ⎕ I can hardly read as all because of severe pain in my neck ⎕ I cannot read at all

**Section 5 -- Headaches**

⎕ I have no headaches at all ⎕ I have slight headaches, which come infrequently ⎕ I have moderate headaches, which come infrequently ⎕I have moderate headaches, which come frequently⎕ I have severe headaches, which come frequently

⎕I have headaches almost all the time

**Section 6 -- Concentration**

☐I can concentrate fully when I want to with no difficulty ☐I can concentrate fully when I want to with slight difficulty

☐I have a fair degree of difficulty in concentrating when I want to ☐I have a lot of difficulty in concentrating when I want to

☐I have a great deal of difficulty in concentrating when I want to ☐I cannot concentrate at all

**Section 7 -- Work**

☐I can do as much work as I want to ☐I can only do my usual work, but no more ☐I can do most of my usual work, but no more ☐I cannot do my usual work ☐I can hardly do any work at all ☐I can’t do any work at all

**Section 8 -- Driving**

☐I can drive my car without any neck pain ☐I can drive my car as long as I want with slight pain in my neck ☐I can drive my car as long as I want with moderate pain in my neck ☐I can’t drive my car as long as I want because of moderate pain in my neck ☐I can hardly drive at all because of severe pain in my neck ☐I can’t drive my car at all

**Section 9 -- Sleeping**

☐I have no trouble sleeping ☐ My sleep is slightly disturbed (less than 1 hr sleepless) ☐My sleep is mildly disturbed (1-2 hrs sleepless) ☐My sleep is moderately disturbed (2-3 hrs sleepless) ☐My sleep is greatly disturbed (3-5 hrs sleepless)

☐My sleep is completely disturbed (5-7 hrs sleepless)

**Section 10 -- Recreation**

☐I can travel I am able to engage in all my recreation activities with no neck pain at all ☐I am able to engage in all my recreation activities, with some pain in my neck ☐I am able to engage in most, but not all of my usual recreation activities because of pain in my neck ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck

☐I can hardly do any recreation activities because of pain in my neck ☐I can’t do any recreation activities at all

**Numerical Rating Scale – Neck/Arm**

This questionnaire has been designed to give the doctor information as to how much neck and arm pain you are having right now. For each of the 3 sections below, place an X on the number at the point that best reflects how much pain you are having right now.

Neck Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible

Pain

Right Arm Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible Pain

Left Arm Pain

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Moderate Worst

Pain Pain Possible Pain