Name:
DOB:
Age:
Chart: Date:

www.AdvancedOrthoandPlastics.com
Call 906-225-1321 or 800-462-6367

Family/Primary Doctor: _____ Phone: _____

Emergency Contact: Name _____ Phone: _____

Who referred you to our office? _____

Who else have you seen for this condition? _____

INSTRUCTIONS: Please provide the following information, in detail. This information is required for billing purposes. Failure to provide this information may result in your insurance company denying payment.

Age: _____ Sex: _____ Height: _____ Weight: _____ Dominant Hand: Right _____ Left _____

What are you seeing us for? _____

What date did this start/happen? _____

Is this an injury related to a : (circle one)

Work accident? Yes / No Military accident? Yes / No Auto accident? Yes / No

Other? Yes / No (Please Explain) _____

IF YOU SAID YES to any of the above, please complete the following:

Where were you when this injury happened? (What specific location, i.e. in house, store, parking lot)

_____

What were you doing at the time of the injury? (What specific activity, i.e. walking through door)

_____

What caused the injury? (i.e. struck nose on door, fell struck knee on asphalt)

_____

Describe How your pain started _____

_____

Describe location of pain _____

Name:
DOB:
Age:
Chart: Date:

Pain worse with ☐ Sneezing ☐ Coughing ☐ Standing _____ minutes ☐ Walking distance _____

Do your legs feel ☐ Tired ☐ Weak ☐ Heavy

Describe the pain ☐ Sharp, knife-like ☐ Shock ☐ Burning ☐ Dull Ache

Rate your pain between 1 and 10 (10 being the worst)	Back	Neck	Leg	Arms
Pain is usually (1-10)	_____	_____	_____	_____
At its worst (1-10)	_____	_____	_____	_____

Is the pain ☐ Constant or ☐ Intermittent ☐ With Activity

Does this pain ☐ Keep you awake at night ☐ Wake you out of a sound sleep

Is pain resolved with sitting ☐ yes ☐ no

Is pain improved with leaning forward supported (shopping cart) ☐ yes ☐ no

Do you have any loss of ☐ Bladder Function ☐ Bowel Function

Have you notice: ☐ Clumsy feeling legs ☐ Clumsy hands ☐ Dropping items ☐ Worsening handwriting
☐ Difficulty with buttoning buttons

Have you had any of the following treatments

☐ Acupuncture	☐ Traction	☐ Heat Therapy
☐ Chiropractic Treatment	☐ Osteopathic Treatment	☐ Physical Therapy
☐ Tens (Electrical Stimulation)	☐ Psychotherapy / Psychiatric	☐ Steroid Injections

List ALL previous surgeries

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Past Medical History / Conditions _____

Allergies _____

Physician Prescribed Medications _____

Over the Counter Drugs / Herbs _____

Name:
DOB:
Age:
Chart: Date:

Family History: ☐ Back Pain ☐ Cancer ☐ Heart Attack

☐ Scoliosis ☐ High Blood Pressure ☐ Diabetes ☐ Stroke

Does **back** pain run in the family ☐ yes ☐ no Does **neck** pain run in the family ☐ yes ☐ no

Social History: Occupation/Retired Occupation: _____ Date Retired: _____

Marital Status ☐ M ☐ S ☐ D ☐ W Number of children_____

Tobacco Use _____ Packs/Day _____ Quit when _____ Alcohol / week _____

☐ Recreational Drug Use: _____

Do you have any of the following:

☐ Decreased Hearing
☐ Ringing in Ears
☐ Ear Infections - Frequent
☐ Dizzy Spells
☐ Failing Vision
☐ Double or Blurred Vision
☐ Nose Bleeds - Frequent
☐ Sinus Trouble
☐ Sore Throat - Frequent
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic Cough
☐ Asthma / Wheezing
☐ Short of Breath
On Exertion ☐
Lying Flat ☐
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Palpitations

☐ Irregular Pulse
☐ Heart Attack
☐ Fainting Spells
☐ Swollen Ankles
☐ Leg Pain When Walking
☐ Varicose Veins / Phlebitis
☐ Loss of Appetite - Recent
☐ Indigestion or Heartburn
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Jaundice / Hepatitis
☐ Urinary Infections - Frequent
☐ Kidney Stones / Disease
☐ Venereal / Sexually Transmitted Disease
☐ History of Lyme's Disease
☐ Chronic Fatigue
☐ Weight Loss - Recent
☐ Anemia
☐ Bleed Easily

☐ Cancer
☐ Diabetes
☐ Convulsions
☐ Stroke
☐ Psoriasis / Eczema
☐ Depression
☐ Memory Loss
☐ Phobias
☐ Mental Illness
☐ Headaches - Frequent
☐ Tuberculosis
☐ Glaucoma
☐ Slow Healer

Name:
DOB:
Age:
Chart: Date:

ADVANCED
Center for Orthopedics
and Plastic Surgery

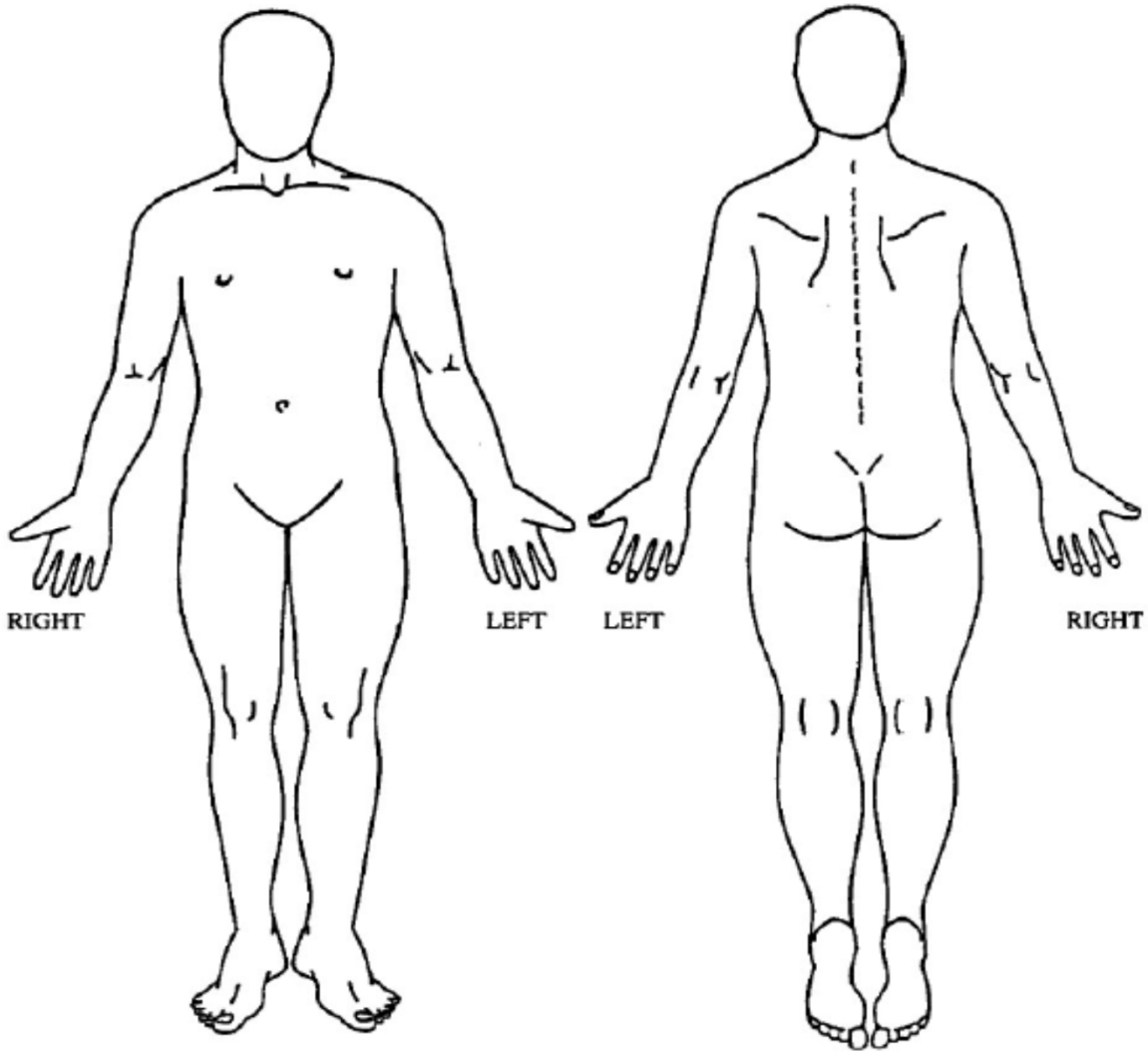
www.AdvancedOrthoandPlastics.com
Call 906-225-1321 or 800-462-6367

NAME: _____ **DOB:** _____

DATE: _____

MARK ON THIS LINE HOW BAD YOUR PAIN IS NOW

NO PAIN (0) _____ **(10) WORSE PAIN**



USING THE DIAGRAMS ABOVE DESCRIBE WHERE YOUR PAIN IS NOW

1. Mark all the areas where sensation is felt on your body using the symbols to the right.
2. Shade all affected areas of radiation.
3. Draw in your face.
4. With an X, mark where your pain is worse now.

v v v ACHING	**x x x BURNING**
= = = NUMBING	**/ / / STABBING**
o o o PINS & NEEDLES	

Name:
DOB:
Age:
Chart: Date:

ADVANCED
Center for Orthopedics
and Plastic Surgery

www.AdvancedOrthoandPlastics.com
Call 906-225-1321 or 800-462-6367

OSWESTRY NECK DISABILITY INDEX

Patient Name _____ DOB _____ Date _____

Visit Type: ☐ preop ☐ 6 weeks ☐ 3 months ☐ 6 months ☐ 12 months ☐ 24 months ☐ other / annual

Instructions: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark the **ONE** answer that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please mark the one which most closely 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
- ☐ 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 every day in most aspects of self care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
- ☐ I can lift heavy weights without causing extra pain
- ☐ I can lift heavy weights, but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g., on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Reading
- ☐ I can read as much as I want with no pain in my neck
- ☐ I can read as much as I want with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can't read as much as I want because of severe pain in my neck
- ☐ I can't 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 with no difficulty
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want
- ☐ I have a lot of difficulty concentrating when I want
- ☐ I have a great deal of difficulty concentrating when I want
- ☐ 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 cannot do any work at all

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive as long as I want with slight pain in my neck
- ☐ I can drive as long as I want with moderate pain in my neck
- ☐ I cannot drive 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 cannot drive my car at all

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour 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 am able to engage in all of my recreational activities with no neck pain at all
- ☐ I am able to engage in all of my recreational activities with some pain in my neck
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck
- ☐ I am able to engage in few of my recreational activities because of pain in my neck
- ☐ I can hardly do any recreational activities because of pain in my neck
- ☐ I cannot do any recreational activities at all

Name:
DOB:
Age:
Chart: Date:

ADVANCED
Center for Orthopedics
and Plastic Surgery

MODIFIED JOA

1. Motor dysfunction score of the upper extremety

- ☐ 0 - Inability to move hands
- ☐ 1 - Inability to eat w/a spoon, but able to move hands
- ☐ 2 - Inability to button shirt, but able to eat w/a spoon
- ☐ 3 - Able to button shirt w/ great difficulty
- ☐ 4 - Able to button shirt w/ slight difficulty
- ☐ 5 - No dysfuntion

2. Motor dysfunction score of the lower extremity

- ☐ 0 - Complete loss of motor and sensory function
- ☐ 1 - Sensory preservation w/o ability to move legs
- ☐ 2 - Able to move legs, but unable to walk
- ☐ 3 - Able to walk on flat floors w/a walking aid (cane or crutch)
- ☐ 4 - Able to walk up and/or down stairs w/ hand rail
- ☐ 5 - Moderate to significant lack of stability, but able to walk up and/or down stairs w/o hand rails
- ☐ 6 - Mild lack of stability but walks on flat ground unaided
- ☐ 7 - No dysfunction

3. Sensory dysfunction score of the upper extremities

- ☐ 0 - Complete loss of hand sensation
- ☐ 1 - Severe sensory loss of pain
- ☐ 2 - Mild sensory loss
- ☐ 3 - No sensory loss

4. Sphincter dysfunction score

- ☐ 0 - Inablity to urinate voluntarily
- ☐ 1 - Marked difficulty w/ urination
- ☐ 2 - Mild to moderate difficulty w/ urination
- ☐ 3 - Normal urination