Name:
DOB:
Age:
Chart: Date:

Center for Orthopedics
and Plastic Surgery

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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

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DOB:
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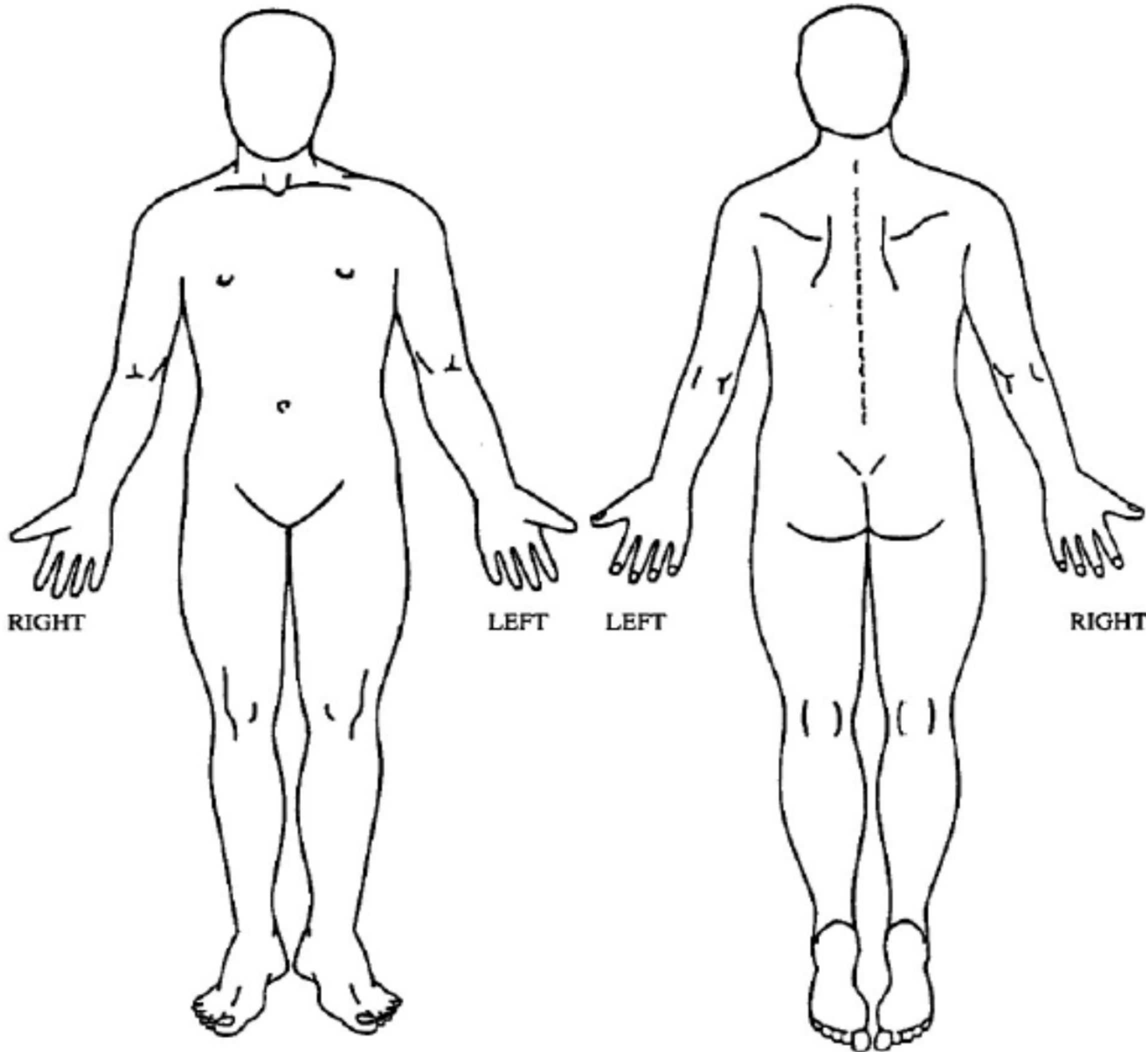
NAME: ______________________________ **DOB:** ______________

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:
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OSWESTRY BACK 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 back 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
- ☐ 0 I have no pain at the moment
- ☐ 1 The pain is very mild at the moment
- ☐ 2 The pain is moderate at the moment
- ☐ 3 The pain is fairly severe at the moment
- ☐ 4 The pain is very severe at the moment
- ☐ 5 The pain is the worst imaginable at the moment

Section 2 - Personal Care
- ☐ 0 I can look after myself normally without causing extra pain
- ☐ 1 I can look after myself normally, but it causes extra pain
- ☐ 2 It is painful to look after myself, and I am slow and careful
- ☐ 3 I need some help but manage most of my personal care
- ☐ 4 I need help every day in most aspects of self care
- ☐ 5 I do not get dressed, wash with difficulty and stay in bed

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

Section 4 – Walking
- ☐ 0 Pain does not prevent me from walking any distance
- ☐ 1 Pain prevents me from walking more than 1 mile
- ☐ 2 Pain prevents me from walking more than 1/2 mile
- ☐ 3 Pain prevents me from walking more than 1/4 mile
- ☐ 4 I can only walk using a crane or crutches
- ☐ 5 I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting
- ☐ 0 I can sit in a chair as long as I like
- ☐ 1 I can only sit in my favorite chair as long as I like
- ☐ 2 Pain prevents me from sitting more than 1 hour
- ☐ 3 Pain prevents me from sitting more than 30 minutes
- ☐ 4 Pain prevents me from sitting more than 10 minutes
- ☐ 5 Pain prevents me from sitting at all

Section 6 – Standing
- ☐ 0 I can stand as long as I want without extra pain
- ☐ 1 I can stand as long as I want but it gives me extra pain
- ☐ 2 Pain prevents me from standing more than 1 hour
- ☐ 3 Pain prevents me from standing more than 30 minutes
- ☐ 4 Pain prevents me from standing more than 10 minutes
- ☐ 5 Pain prevents me from standing at all

Section 7 – Sleeping
- ☐ 0 Pain does not prevent me from sleeping well
- ☐ 1 I sleep well only by using pain medication
- ☐ 2 Even when I take pain medication I have less than 6 hours sleep
- ☐ 3 Even when I take pain medication I have less than 4 hours sleep
- ☐ 4 Even when I take pain medication I have less than 2 hours sleep
- ☐ 5 Pain prevents me from sleeping at all

Section 8 – Sex Life (if applicable)
- ☐ 0 My sex life is normal and causes no extra pain
- ☐ 1 My sex life is normal but it causes extra pain
- ☐ 2 My sex life is nearly normal but is very painful
- ☐ 3 My sex life is severely restricted because of pain
- ☐ 4 My sex life is nearly absent because of pain
- ☐ 5 Pain prevents any sex life at all

Section 9 – Social Life
- ☐ 0 My social life is normal and gives me no extra pain
- ☐ 1 My social life is normal but increases the degree of pain
- ☐ 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ☐ 3 Pain has restricted my social life and I do not go out as often
- ☐ 4 Pain has restricted my social life to my home
- ☐ 5 I have no social life because of pain

Section 10 – Traveling
- ☐ 0 I can travel anywhere without extra pain
- ☐ 1 I can travel anywhere but it gives me extra pain
- ☐ 2 The pain is bad but I manage journeys over 2 hours
- ☐ 3 Pain restricts me to journeys of less than 1 hour
- ☐ 4 Pain restricts me to short necessary journeys under 30 minutes
- ☐ 5 Pain prevents me from traveling except to the doctor or hospital