NEW PATIENT HISTORY – Dr. Gabriel

Patient Name:____ Age: _____ DOB: ___/___/_______ Date: ___/___/2017

Reason for today's visit: ____

Hand Dominance: Right Left Date of Onset: _______________ Date of Injury:________________

Injury occurred at: _____ Home ______ Work _____ MVA Other: ____

This condition is: ______ New ______ Chronic ______ Recurring ______ Reinjured

WHAT MAKES YOUR PAIN WORSE?

_____ Sitting _____ Stooping
_____ Standing _____ Twisting
_____ Walking _____ Coughing
_____ Bending _____ Sneezing
_____ Lying _____ Other

_____ Difficulty with sleeping Are you on aspirin or another blood thinner? _____No ___Yes

Allergies: ____

Past medical history: ____

____

Past surgical history: ____

Family history: ____

Social history: Do you **smoke**? _____ No _____ Yes _____ Quit _____ Packs/Day ______ How many years?

Illicit drug abuse/overuse: _____Never _____Currently _____In the past **Alcohol**: ___No ___Yes How often__________

Working: _____ No _____ Yes Retired: _____ No _____ Yes Occupation: __________________________________

(please circle) **NO PAIN** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **SEVERE PAIN**

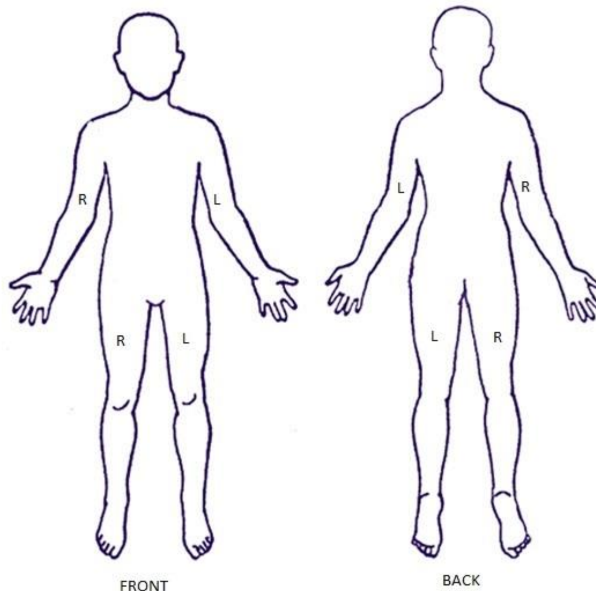
Types of pain:

Dull:
uuuuuuu

Pins and Needles:
+++++++++

Sharp:
!!!!!!!!!!!

Numbness:
oooooooo



Pain is:
______Constant

______ Intermittent

Patient signature____

Vital Signs: Temp____ BP____/____ Pulse____ Respirations____ Weight_____lbs, Height_____in. BMI_____

Patient Name:___________________________ **DOB:** ___/______/______ **Today's Date:** _____/_____/_______

CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY (How often the med is taken)	Prescribing Doctor

CHIEF COMPLAINT

Spine Institute of Ohio

Patient Name:_________________________ Age:______ DOB:___/___/___ DOV:___/___/___
Chief Complaint:____
Date on Injury/Onset:______________________________ Problem: New / Chronic / Re-injury

Pain Location(s):

- ☐ Neck
- ☐ Interscapular
- ☐ Thoracic
- ☐ Low Back Pain
- ☐ Buttock Pain- R L
- ☐ Back of thigh- R L
- ☐ Anterior/ Lateral Thigh Pain / Numbness- R L
- ☐ Flank Pain- R L
- ☐ Groin Pain- R L
- ☐ Headaches- Yes / No
- ☐ Pain back of head (occipital) Yes / No
- ☐ Migraines: Yes / No

Pain Duration:

Days __________
Weeks:_________
Months:________
Years:__________

Treatment History: (Please Circle)

Physical Therapy	Help	No Help
NSAIDs/Medication	Help	No Help
Chiropractic	Help	No Help
Bracing	Help	No Help
Steroids/Medrol Pack	Help	No Help
Prior Spine Surgery	Help	No Help
Water Therapy	Help	No Help
TENS Unit	Help	No Help
Acupuncture	Help	No Help
Epidural Injections	Help	No Help
Facet Injections	Help	No Help
RFA/Nerves Burned	Help	No Help
Medial Branch Blocks	Help	No Help

Leg pain **MORE THAN** back pain_____
Back pain **MORE THAN** leg pain_____
Complains of **Weakness** in **Legs**: Right / Left
Complains of **Weakness** in **Arms**: Right / Left

Thigh / Leg / Foot / Toes: **Pain** / Radiculopathy: Right / Left
Thigh / Leg / Foot / Toes: **Parasthesias** / Numbness / Tingling: Right / Left

Arm / Forearm / Hand / Fingers: **Pain** / Radiculopathy: Right / Left
Arm / Forearm / Hand / Fingers: **Parasthesias** / Numbness / Tingling Right / Left

Myelopathy Cord Symptoms: Drop Small Items Loss of Dexterity Hands Difficulty with Zippers/Buttons

(Cervical / Thoracic) Loss of Balance Wobble Unsteadiness

- ☐ **Urinary Retention**
- ☐ **Perineal Numbness**
- ☐ **Wetting**
- ☐ **BM –Unable to Control**
- ☐ Urinary Frequency
- ☐ Difficulty Starting Urinary stream
- ☐ Occasional wetting with couging

STENOSIS / Neurogenic Claudication Symptoms: ___ **Leans on Counters / Shopping Cart**

Walking Distance: ___<1/2 block ___1 block ___> 1 block **Uses Aide:** Wheelchair / Walker / Cane

How many Minutes Can You Stand Without Pain? ___ 0-10 ___15-30 ___30-60+ ____Jog / Run

Thoracic: Pain / Radiculopathy / Parasthesias / Numbness / Tingling: Right / Left

Physician Signature:____________________________ MA Initials ____________________________________

REVIEW OF SYSTEMS

Check all that apply

Patient Name:____________________________________ **Date: ____/____/20____**

General:

____Fevers	____Chills	____Sweats	____Anorexia
____Fatigue	____Malaise	____Weight gain	____Weight loss

Eyes:

____Wears glasses	____Wears contacts	____Blurring vision	____Double vision
____Change in vision	____Wears bifocals	____Discharge	____Watering
____Vision loss	____Eye pain	____Photophobia	____Glaucoma

Ears/Nose/Throat

____Ear ache	____Ear discharge	____Ringing in ear	____Hearing loss
____Sinus problems	____Nosebleeds	____Sore throat	____Hoarseness
____Difficulty swallowing	____Nasal polyps	____Mouth lesions	____Bleeding gums
____Change in your voice			

Cardiovascular:

____Chest pain	____Palpitations	____ Dyspnea on exertion	____ Syncope
____Peripheral edema	____Heart murmur	____Hypertension	____Heart attack
____Stroke	____Heart disease		

Respiratory:

____Cough	____Short of breath	____Excessive sputum	____Cough up blood
____Wheezing	____Tuberculosis	____Recent pneumonia	____Chest tightness
____Inspiration pain	____Snoring	____Asthma	____COPD

Genitourinary:

____Difficulty with urination	____Blood in urine	____Discharge	____Frequent urination
____Urinary hesitancy	____Urinary urgency	____**Urinary retention**	____Flank pain
____Urination at night	____Burning on urination	____**Bowel incontinence**	____Genital sores
____Decreased libido	____Pregnant	____**Bladder incontinence**	

Gastrointestinal:

____Nausea	____Heartburn	____Loss of appetite	____Hemorrhoid
____Vomiting	____Gastric reflux	____Abdominal pain	____Hematocheza
____Difficulty swallowing	____Bloody stool	____Diarrhea	____Melena
____Change in bowel habits	____Hepatitis	____Black tarry stool	____Constipation
____Jaundice	____History of Ulcers		

Musculoskeletal:

____Back pain	____Stiffness	____Joint pain	____Joint swelling
____Muscle cramps	____Muscle weakness	____Arthritis	____Instability
____Redness to joints	____Joint feels hot		

Skin:

____Rash	____Itching	____Dryness	____Suspicious lesions
____Excessive bruising	____Skin changes	____Redness	____Poor healing

Circulatory:

____Swollen ankles	____Calf cramps with walking		

Neurologic:

____Transient paralysis	____Vertigo	____Seizures	____Tremors
____Dizziness	____Blackouts	____Headaches	____Migraines
____Weakness	____Numbness	____Tingling	

Psychiatric:

____Depression	____Anxiety	____ Mental disturbance	____ Memory loss
____Suicidal ideations	____hallucinations	____Paranoia	____Chronic pain

Endocrine:

____Cold intolerance	____Heat intolerance	____Frequently thirsty	____Frequently hungry
____Recent weight change	____History of diabetes	____Changes in skin texture	____Thyroid disease

Heme/Lymphatic:

____Abnormal bruising	____Enlarged lymph nodes	____ Takes blood thinners	____ Bleeding

Allergic/Immunologic:

_____Hives	_____Hay fever	____Persistent infections	____HIV exposure

MEDICAL HISTORY QUESTIONNAIRE

Please check any of the following that apply to your medical history

Patient Name__________________________________ **DOB**____________________________ **Date**_______________

___ Headaches
___Migraines
___Seizures/Epilepsy
___Depression
___Anxiety
___Mental health issues
___Insomnia
___Sleep Apnea
___ Hearing Loss
___Ringing in the Ears
___Glaucoma/Cataracts
___Fatigue
___Stroke
___Thyroid Disease
___Dizziness/Fainting
___Weakness
___Chest Pain
___Heart Murmur
___Heart Palpitations
___Heart Disease
___High Blood Pressure
___Low Blood Pressure
___Circulation Problems
___Bleeding Tendency
___Anemia

___Shortness of Breath
___Wheezing
___Asthma
___ Pneumonia
___Tuberculosis (TB)
___Heartburn/Indigestion
___Ulcer
___Abdominal Pain
___Bowel Irregularity
___Rectal Bleeding
___Hemorrhoids
___Gallbladder Disease
___Bladder Infections
___Incontinence
___Prostate Problems
___Kidney Disease
___STD
___HIV +/ AIDS
___Hepatitis
___Sexual Dysfunction
___Infertility
___Arthritis
___Osteoporosis
___Gout
___Neck Pain

___Hives
___Chronic Rash
___Diabetes
___Cancer
___Weight Loss
___Weight Gain
___Measles
___Mumps
___Chickenpox
___Whooping Cough
___Polio
___Tetanus
___Erectile Difficulties
___Blood Transfusion
___Leg Pain/Swelling
___Back Pain
___Bursitis/Tendonitis
___History of + Antibodies
___Other:_______________________

SPINE INSTITUTE OF OHIO

New Patient Registration Form

PATIENT INFORMATION

Name: ____
Nickname: _______________________________________
Address:____
City: ___________________ State: ______ Zip: ________
Phone – Home:___________________________________
Phone – Cell: ____________________________________
Pharmacy Name: _________________________________
Phone: __________________ Fax: ___________________

PATIENT EMPLOYMENT

( )Employed ( )Disabled ( )Retired
( )Not employed ( )Student ( )Other
Occupation: _____________________________________
Work phone:_____________________________________
Employer: _______________________________________
( )Work Comp ( )Liability Claim ( )Auto
Case/Injury #: ___________________________________

PRIMARY INSURANCE

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:__________________________________
Subscriber's Name: _____________________________
Subscriber's SSN:________________________________
Subscriber's Date of Birth: _______________________
Insurance ID #:__________________________________
Insurance Carrier: _______________________________
Policy Group #: __________________________________

SECONDARY INSURANCE

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:__________________________________
Subscriber's Name: _______________________________
Subscriber's SSN:_________________________________
Subscriber's Date of Birth__________________________
Insurance ID #:__________________________________
Insurance Carrier: _______________________________
Policy Group #: __________________________________

Patient Confidentiality Release:

In the event that we/Spine Institute of Ohio cannot reach you, we would like your permission to leave a message on your voicemail or home answering machine regarding upcoming appointments, tests, surgical procedures, and test results.

( ) I agree to this authorization
( ) I deny this authorization

Date: _________________
Co-pay $__________ EMR ID#:_____________
Email:
____

Sex: ( )Male ( )Female
Date of Birth: __________________________________
Social Security #: _______________________________
Marital Status: ( )Married ( )Divorced ( )Single
( )Widowed ( )Separated
Emergency Contact: _____________________________
Relationship: _________ Phone: ___________________

Race:_______ Ethnicity: ________ Language: ________

Smoking Status:( )Never ( )Current
( )Former ( ) Packs per Day ____

CONTACTS

Family Physician: Dr.______________________________
Referring Physician: Dr.___________________________
Other Physician: Dr.______________________________

GUARANTOR

( )Same as patient ( )Same as guarantor ( )Other
Insured's Name:_________________________________
Subscriber's Name: ______________________________
SSN:____
Date of Birth: __________________________________
Insurance ID #:__________________________________
Insurance Carrier: ______________________________
Policy Group #: _________________________________

Authorization to Provide Care:

( ) I authorize the providers of the Spine Institute of Ohio to provide any medical care deemed necessary according to their professional opinions.

I also authorize my Physician(s) and Spine Institute of Ohio to photograph me for medically related documentation purposes.

Notice to Patients: Receipt of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish.

( ) I acknowledge that I have received a copy of the Spine Institute of Ohio's notice of Privacy Practices.

( ) I was offered a copy of the Spine Institute of Ohio's notice of Privacy Practices, but declined it.

Patient/Guardian Signature: _______________________

Spine Institute of Ohio
Josue P. Gabriel, MD
ORTHOPAEDIC SPINE SURGEON

3535 Fishinger Blvd., Suite 280
Hilliard, OH 43026
Phone: (614) 222-0743
Fax: (614) 222-0744

MEDICATION POLICY

Due to the increased scrutiny by State and Federal regulators, it has become necessary to further enhance our compliance program as it relates to controlled substance prescriptions and the management of your pre and post-operative pain. Therefore, **one or all of the following conditions of treatment may be in effect** in order to receive your prescriptions with our office:

1. A signed Medication Policy Agreement
2. Random/scheduled toxicology screenings
3. Random pill count
4. Any other practice imposed conditions of care.

By signing this Medication Policy, you are agreeing to the following;

- I do not have current problems with substance abuse or dependence (addiction).
- I am not currently involved in the sale, diversion, illegal possession or transport of controlled substances.
- **I agree to take my medications exactly as prescribed by my doctor.**
- I agree to submit a urine specimen at my doctor's request to test for compliance.
- I agree to allow my doctor to contact family members or friends to help monitor my progress if necessary.
- I will allow other relevant healthcare providers to communicate with my physician regarding my medication use.
- I understand that **NO ALLOWANCE** will be made for lost or stolen prescriptions of drugs.
- If I am a female, I certify that I am not pregnant and will use appropriate measures to prevent pregnancy during the course of this treatment.
- I agree to follow the advice of healthcare providers in regard to stopping controlled substances if it is felt necessary.
- No refills of medications will be made after hours, during weekends, or during holiday periods.
- I am responsible for making an appointment or calling the office for a refill at least **72 hours** before running out of my medication.
- I will obtain my prescriptions from the following pharmacy:_________________________ located at ____ and give Spine Institute of Ohio permission to contact any other pharmacy to enquire about additional medications.
- Dr. Gabriel will prescribe pain medications up to **3 months after surgery**. If you continue to need narcotics after this time, you will be referred to a pain management physician.
- I understand that SIO will only refer me to a **maximum of TWO** pain management offices. If I am discharged from a pain management office, Dr. Gabriel **WILL NOT** refer me to another doctor. I will be responsible for obtaining my own appointment with no referral from SIO.
- If you are called in for a urine drug screen or pill count and do not show to your appointment you will not be given any medication.
- If your urine drug screen discloses non-prescribed medication in your urine, illegal drugs, or the medication that we prescribe does not show in your urine, you will not receive a prescription.
- **Patient Authorization for Pharmacy Benefits Manager**
  I authorize the physician and/or staff of Spine Institute of Ohio to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

I have read this document, understand it, and have had all questions answered satisfactorily. I consent to the use of medications to help control my pain and I understand that this treatment will be conducted in accordance with the conditions stated above.

Patient Signature:____ Date:_____/______/_______

PATIENT FINANCIAL RESPONSIBILITY POLICY and HIPPA

Insurance/ Billing

****It is important for you to be an informed consumer, who understands the specifications of your insurance policy (e.g., Specialty doctor visit coverage, referral/authorization requirements for specialty care,).*** Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

*Spine Institute of Ohio contracts with many insurance plans. Before your appointment, please be sure we are in-network and the services are covered under your plan. If we are out of-network, you will be billed for the cost of care.

*If your insurance carrier is not one with which we participate, you will be responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full.

***You must present your insurance card at each visit**. As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. . After hearing from your insurance company we will send you a bill that reflects your balance due. Payment in full is expected at this time. If payment cannot be made in full, you are expected to contact our billing company to make payment arrangements.

*It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information. We mail out appointment information, surgery information, in addition to billing statements.

*If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

***All co-pays must be paid at the time of your visit**

*Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We accept cash, check and most major credit cards. There will be a **$30.00 fee for all returned checks**.
*Refunds from services charged on a credit card will be returned to the same credit card. I understand that I am financially responsible for services rendered in the office and surgical procedures. Failure to pay for services or any residual account balance that is not paid will be placed to a collection agency and possibly negatively affect my credit report. I authorize my insurance benefits to be paid directly to Spine Institute of Ohio. I authorize the release of any information by the Spine Institute of Ohio and/or Billing Contractor Agency to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made. Also, to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted. We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. Health4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health4, we participate in joint activities that include utilization review, quality assessment and improved activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health4.

* **Spine Institute of Ohio requires a 24hr cancellation notice,** Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment **you will be required to pay a $25.00 rescheduling fee** prior to rescheduling your next appointment. Payment can be made via cash or credit card only.

***There will be a fee for filling out forms of $25.00 per form** (disability, etc.), the fee is to be paid in advance. It may take up to a week to fill out the form, and we will notify you when it is done.

***Medical records requests may take up to 30 days for processing and can incur charges of up to $25.00.**

Patient Authorization for PPO and HMO Patients
I authorize the physician and/or staff of Spine Institute of Ohio to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named Insurance Company to pay directly to Spine Institute of Ohio the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my Insurance company.

Patient Authorization for Medicare Patients
I authorize the physician and/or staff of Spine Institute of Ohio to release to Social Security Administration, Health Care Financing Administration, or its Intermediaries or Carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare. Spine Institute of Ohio is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare or my supplement insurer.

Patient Authorization for Medicaid patients
Spine Institute of Ohio is **not** a contracted provider with any Medicaid product, therefor we cannot bill for any services provided by us to any Medicaid carrier. I understand that by continuing to be seen as a patient at Spine Institute of Ohio I assume all financial responsibility for services provided.

I, the undersigned, agree that if payment on this patient's account is not made, I will pay reasonable attorney's fees and collection fees incurred for the collection process. I authorize the release of credit information to the appropriate information gathering services.
I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms.
Responsible Party: ______________________________ Relationship to patient: Self Parent Guardian

Patient Signature: _______________________________
Printed Name: ____ Date: _______

Sharing of Medical Information

I give the physician(s)/office staff of Spine Institute of Ohio permission to discuss my medical condition with the following individuals:

Name: ____ Relationship: ___________________________

Name: ____ Relationship: ___________________________

Messages

Please call: [ ] my home [ ] my work [ ] my cell Number:___________________
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

Patient Signature: ____ Date: _________________

Special Accommodation Authorization
If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Spine Institute of Ohio of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Spine Institute of Ohio is the patient's responsibility.

Patient Signature: ____ Date: _________________

Parent/Guarantor/Guardian Signature: ____

SF-12© **Patient Questionnaire**

Patient Initials: ___________ Date of Birth: _________________ Patkey: _____________________________

Surgeon Name: Josue P. Gabriel, M.D. Date: _______________________________

Examination Period: ____ Preop (1) ____ 1 Year (3) ____ 5 Year (5)
____ Immediate postop (2) ____ 3 Year (4) ____ Other (specify)(6):_______________

SF-12©

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a checkmark on the line in front of the appropriate answer. It is not specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
____ Excellent (1) ____ Fair (4)
____ Very Good (2) ____ Poor (5)
____ Good (3)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf:
____ Yes, limited a lot (1)
____ Yes, limited a little (2)
____ No, not limited at all (3)

3. Climbing SEVERAL flights of stairs:
____ Yes, limited a lot (1)
____ Yes, limited a little (2)
____ No, not limited at all (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
____ Yes (1) ____ No (2)

5. Were limited in the KIND of work or other activities:
____ Yes (1) ____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
____ Yes (1) ____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:
____ Yes (1) ____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
____ Not at all (1) ____ Quite a bit (4)
____ A little bit (2) ____ Extremely (5)
____ Moderately (3)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

10. Did you have a lot of energy?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

11. Have you felt downhearted and blue?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
____ All of the time (1) ____ Some of the time (4)
____ Most of the time (2) ____ A little of the time (5)
____ A good bit of the time (3) ____ None of the time (6)

Surgeon Signature
____

Date _______________________

Oswestry Disability Index for Back Pain

Patient Name ______________________________ DOB ____________ Date ______________

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which closely describes your problem *right now*.

Section 1 – Pain intensity

A. My pain is mild to moderate. I do not need painkillers.
B. The pain is bad, but I manage without taking painkillers.
C. Painkillers give complete relief from pain.
D. Painkillers give moderate relief from pain.
E. Painkillers give very little relief from pain.
F. Painkillers have no effect on the pain.

Section 2 – Personal Care (washing, dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help everyday in most aspects of self-care.
F. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

Section 4 – Walking

A. I can walk as far as I wish.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can walk only if I use a cane or crutches.
F. I am in bed or in a chair for most of every day.

Section 5 – Sitting

A. I can sit in any chair for as long as I like.
B. I can sit in my favorite chair only, but for as long as I like.
C. Pain prevents me from sitting for more than 1 hour.
D. Pain prevents me from sitting for more than ½ hour.
E. Pain prevents me from sitting for more than 10 minutes.
F. Pain prevents me from sitting at all.

Section 6 – Standing

A. I can stand as long as I want without extra pain.
B. I can stand as long as I want, but it gives me extra pain.
C. Pain prevents me from standing for more than 1 hour.
D. Pain prevents me from standing for more than ½ hour.
E. Pain prevents me from standing for more than 10 minutes.
F. Pain prevents me from standing at all.

Section 7 – Sleeping

A. Pain does not prevent me from sleeping well.
B. I sleep well but only when taking medicine.
C. Even when I take medication I sleep for less than 6 hours.
D. Even when I take medication I sleep for less than 4 hours.
E. Even when I take medication I sleep for less than 2 hours.
F. Pain prevents me from sleeping at all.

Section 8 – Social Life

A. My social life is normal and causes me no extra pain.
B. My social life is normal but increases the degree of pain.
C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
D. Pain has restricted my social life and I do not go out as often.
E. Pain has restricted my social life to my home.
F. I have no social life because of pain.

Section 9 – Sexual Activity

A. My sexual activity is normal and causes no extra pain.
B. My sexual activity is normal but causes some extra pain.
C. My sexual activity is nearly normal but is very painful.
D. My sexual activity is nearly absent because of pain.
E. Pain prevents any sexual activity at all.

Section 10 – Traveling

A. I can travel anywhere without extra pain.
B. I can travel anywhere but it gives me extra pain.
C. Pain is bad, but I manage journeys over 2 hours.
D. Pain restricts me to journeys of less than 1 hour.
E. Pain restricts me to necessary journeys under ½ hour.
F. Pain prevents traveling except to the doctor/hospital.

Score % _______________

Signature ____

BACK PAIN & LEG PAIN
Visual Analog Scale

Patient Name ________________________________ DOB ____________ Date_____________

Interval:

☐ Baseline ☐ 42-day ☐ 90-day ☐ 180-day
☐ 365-day ☐ 730-day ☐ 3 years ☐ 4 years
☐ 5 years ☐ 6 years ☐ 7 years ☐ Other, specify __________

Leg pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your leg pain by marking a single **|** on the line that describes your current level of leg pain TODAY, ranging from “no pain” to “worst possible pain.”

Right leg |--|---|

No pain 5 Worst possible pain
0 10

Left leg |--|---|

No pain 5 Worst possible pain
0 10

Back pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your back pain by marking a single **|** on the line that describes your current level of back pain TODAY, ranging from “no pain” to “worst possible pain.”

|--|--|

No pain 5 Worst possible pain
0 10

Patient initials _______________ Date __________________

Confirmation of investigator review

Signature of investigator ____ Date __________________

Neck Disability Index

Patient Name _______________________________ DOB _____________ Date _______________

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which closely describes your problem *right now*.

Section 1 – Pain intensity

G. I have no pain at the moment
H. The pain is mild at the moment.
I. The pain comes and goes and is moderate.
J. The pain is moderate and does not vary much.
K. The pain is severe but comes and goes.
L. The pain is severe and does not vary much.

Section 2 – Personal Care (washing, dressing, etc.)

G. I can look after myself without causing extra pain.
H. I can look after myself normally, but it causes extra pain.
I. It is painful to look after myself and I am slow and careful.
J. I need some help but manage most of my personal care.
K. I need help everyday in most aspects of self-care.
L. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

G. I can lift heavy weights without extra pain.
H. I can lift heavy weights but it gives extra pain.
I. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
J. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
K. I can lift very light weights.

Section 4 – Reading

G. I can read as much as I want to with no pain in my neck.
H. I can read as much as I want with slight pain in my neck.
I. I can read as much as I want with moderate pain in my neck.
J. I cannot read as much as I want because of moderate pain in my neck.
K. I cannot read as much as I want because of severe pain in my neck.
L. I cannot read at all.

Section 5 – Headache

G. I have no headaches at all.
H. I have slight headaches which come infrequently.
I. I have moderate headaches which come infrequently.
J. I have moderate headaches which come frequently.
K. I have severe headaches which come frequently.
L. I have headaches almost all the time.

Score % _______________

Signature: _________________________________

Section 6 – Concentration

G. I can concentrate fully when I want to with no difficulty.
H. I can concentrate fully when I want to with slight difficulty.
I. I have a fair degree of difficulty in concentrating when I want to.
J. I have a lot of difficulty in concentrating when I want to.
K. I have a great deal of difficulty in concentrating when I want to.
L. I cannot concentrate at all.

Section 7 – Work

G. I can do as much work as I want to.
H. I can only do my usual work but no more.
I. I can do most of my usual work but no more.
J. I cannot do my usual work.
K. I can hardly do any work at all.
L. I cannot do any work at all.

Section 8 – Driving

G. I can drive my car without neck pain.
H. I can drive my car as long as I want with slight pain in my neck.
I. I can drive my car as long as I want with moderate pain in my neck.
J. I cannot drive my car as long as I want because of moderate pain in my neck.
K. I can hardly drive my car at all because of severe pain in my neck.
L. I cannot drive my car at all.

Section 9 – Sleeping

F. I have no trouble sleeping.
G. My sleep is slightly disturbed (less than 1 hour sleepless).
H. My sleep is mildly disturbed (1-2 hours sleepless).
I. My sleep is moderately disturbed (2-3 hours sleepless).
J. My sleep is greatly disturbed (3-5 hours sleepless).
K. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

G. I am able to engage in all recreational activities with no pain in my neck at all.
H. I am able to engage in all recreational activities with some pain in my neck.
I. I am able to engage in most but not all recreational activities because of pain in my neck.
J. I am able to engage in few of my usual recreational activities because of pain in my neck.
K. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all

NECK PAIN & ARM PAIN
Visual Analog Scale

Patient Name ________________________________ DOB ____________ Date ___________

Interval:

☐ Baseline	☐ 42-day	☐ 90-day	☐ 180-day
☐ 365-day	☐ 730-day	☐ 3 years	☐ 4 years
☐ 5 years	☐ 6 years	☐ 7 years	☐ Other, specify __________

Arm pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your arm pain by marking a single **|** on the line that describes your current level of arm pain TODAY, ranging from "no pain" to "worst possible pain."

Right arm |--|---|

No pain 1 — 5 — Worst possible pain 10

Left arm |--|---|

No pain 1 — 5 — Worst possible pain 10

Neck pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your neck pain by marking a single **|** on the line that describes your current level of neck pain TODAY, ranging from "no pain" to "worst possible pain."

|--|---|

No pain 1 — 5 — Worst possible pain 10

Patient initials _______________ Date __________________

Confirmation of investigator review

Signature of investigator ____ Date ___________________