ORTHO MONTANA

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THE FOOT & ANKLE CENTER
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THE HAND CENTER
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THE SPINE CENTER
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THE SPORTS MEDICINE CENTER
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THE TRAUMA CENTER
Brian J. Drake, DO
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THE PEDITRIC CENTER
Heather D. Hansen, MD

PM&R
Lindsey J. Beck, DO

Dear Patient,

We would appreciate it is you would take the time to fill out the enclosed forms. Your answers are important to our understanding of your problem(s) and guide us in your case. These forms may take 25-30 minutes to compete and needs to be completed before your visit and brought with you to your scheduled appointment. Please do not mail them to us as they may not reach us in time for your appointment.

Your response to the questions will be held in the strictest confidence. It is important to answer each question. If you are not sure how to answer a question, please give the best answer you can and then make an additional comment in the margin. This information is very important in making the correct diagnosis, aids in a more accurate examination and minimizes any delay in treatment. Failure to complete the forms before your appointment may result in rescheduling your visit.

Please send or bring any relevant X-RAYS, MRI, CAT SCAN, MYELOGRAM, EMG, NCS and copies of YOUR medicals records from other physicians that may relate to your spine.

Thanks you for your time and completeness. We look forward to meeting you and appreciate you choosing us to provide your spine care.

Sincerely,

Your Spine Team

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THE CENTERS OF EXCELLENCE
ORTHO MONTANA

Dr_____ **Date**_____

Patient Name_____

Patient #_____

LUMBAR SPINE DATABASE

Please list the doctors you have seen in the last year relating to your back pain:

Type of Doctor	Doctor's Name	Location (city/town)
Chiropractor		
Neurologist		
Internist/Family		
Surgeon		
Physiatrist (Rehab)		
Pain Clinic Doctor		

Chief Complaint (circle only one) Back pain Left leg pain Right leg pain

What question would you most like us to address today?

History of Present Illness

What kind of problem are you having?

When did it begin?

What caused it?

Please list previous spine surgeries (only on back)

Surgery	Surgeon	Location	Did it help?

Patient Name_____Date of Birth_____Patient #_____

	Yes	No	If yes, where?
Is there associated weakness in the leg?			
Is there associated numbness or tingling in the leg?			
Do you experience muscle cramps or spasms in the leg?			
Do your muscles twitch or move (unintentionally) in your leg?			

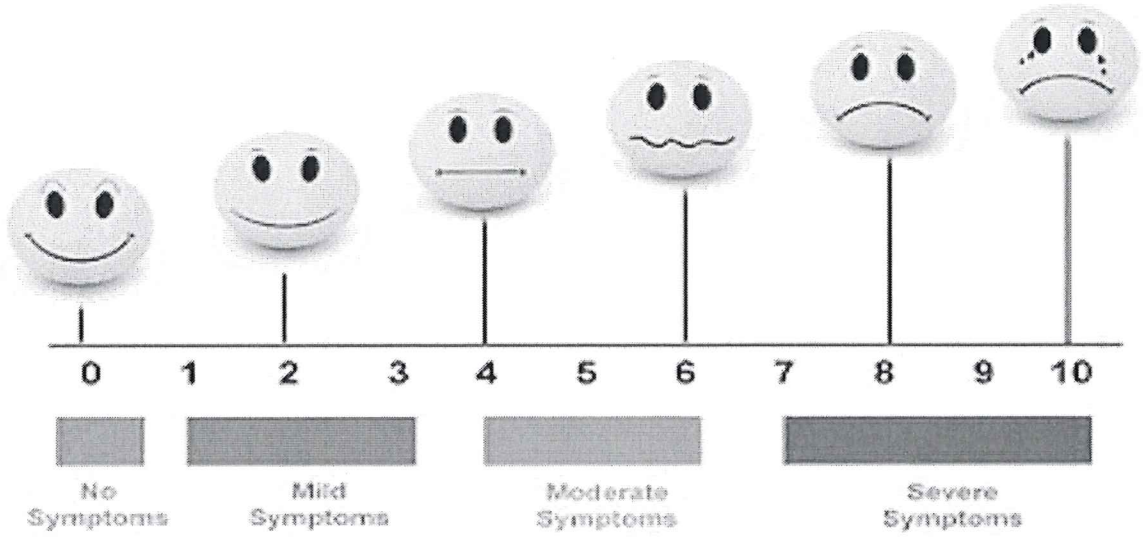
Estimate your walking tolerance in city blocks: _____#blocks and/or_____minutes,_____not limited.

Where is the pain? (mark all that apply)

	Groin		Inside of ankle and foot
	Buttocks		Bottom of foot
	Back of thigh and calf		Outer side of ankle
	Outer thigh		Front of thigh only to knee
	Top of foot toward big toe		Front of Shin

Currently my symptoms of pain are _____worsening _____improving _____persisting at the same level.

Universal Pain Assessment Tool



1-3: Pain is **tolerable** and does **NOT** limit activities
4-6: Pain is **distressing** and I am unable to do **SOME** activities because of pain
7-10: Pain is **unbearable** and I am unable to do **ANY** activity because of pain

Please use the scale below to help you rate your average pain over the last week.
Document your number at the bottom of the following page. *Do not write on this page.*

0 Pain free.
1 Very minor annoyance. (You experience an occasional and minor twinge.)
2 Minor annoyance. (You experience an occasional yet strong twinge.)
3 Annoying enough to be distracting.
4 Can be ignored if you are really involved in your work (but still distracting.)
5 Cannot be ignored for more than 30 minutes.
6 Cannot be ignored for any length of time.
7 Makes it difficult to concentrate and interferes with sleep. (You are able to function with effort.)
8 Physical activity is severely limited. (You are able to read and converse with effort. Nausea and dizziness set in as factors of pain.)
9 Crying out or moaning uncontrollably; near delirium.
10 Unconscious or pain that makes you want to pass out.

THE CENTERS OF EXCELLENCE
ORTHO MONTANA

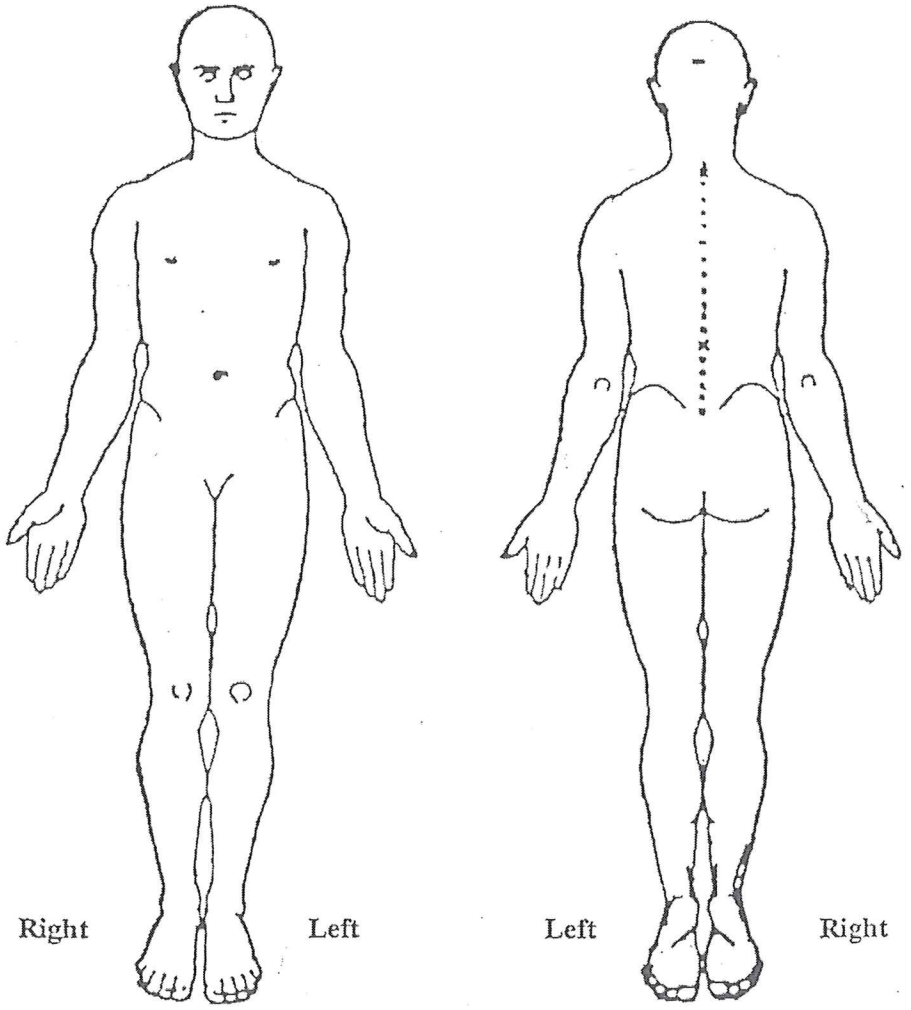
Patient Name_____

Date of Birth_____**Patient #**_____

PATIENT PAIN DIAGRAM

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the 5 different symbols. Include all affected areas.

Aching Δ Δ Δ | Numbness = = = | Pins and needles O O O | Burning × × × | Stabbing / / /



Please circle a number on the scale below relating to how bad your pain is on average over the last 7 days without pain medications.

Neck pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Arm pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Back pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Leg pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain

THE CENTERS OF EXCELLENCE
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Patient Name_____

Date of Birth_____**Patient #**_____

Are you currently having problems with:

Abdominal Pain	Yes	No	Fainting	Yes	No
Allergies (environmental/food)	Yes	No	Headaches	Yes	No
Bleeding Problems	Yes	No	Intolerance to heat or cold	Yes	No
Blood in Stool	Yes	No	Incontinence	Yes	No
Blurred Vision	Yes	No	Loss of Sleep	Yes	No
Bowel Changes	Yes	No	Lymphadenopathy	Yes	No
Burning with Urination	Yes	No	Mental Status Changes	Yes	No
Chest Pain	Yes	No	Muscle Aches (Abnormal)	Yes	No
Circulation	Yes	No	Neck Swelling	Yes	No
Constipation	Yes	No	Night Pain	Yes	No
Cough (Productive)	Yes	No	Night Sweats	Yes	No
Coughing up Blood	Yes	No	Pain with Urination	Yes	No
Diarrhea	Yes	No	Palmar Erythema	Yes	No
Dizziness	Yes	No	Palpitations	Yes	No
Difficulty Breathing	Yes	No	Skin Rash or Lesions	Yes	No
Dyspepsia	Yes	No	Unexplained Weight Loss/Gain	Yes	No
Edema	Yes	No	Urethral Discharge	Yes	No
Excessive Thirst	Yes	No	Urinary Frequency	Yes	No
Eye Prominence	Yes	No	Wheezing	Yes	No

Patient Name_____Date of Birth_____Patient #_____

What makes your pain better? (mark all that apply)

	Sitting down		Bending forward		Unloading the spine
	Change of position		Bending backward		Lying Down
			Leaning on the shopping cart		

What makes your pain worse? (mark all that apply)

	Standing		Bending Forward
	Walking		Bending Backward
	Lifting		Rotating hip
	Coughing or sneezing		Extending leg

Do you have any of the associated symptoms? (mark all that apply)

	Limp		Groin Pain		Unexplained weight loss
	Loss of urine		Constipation		Night Pain
	Loss of stool		Urinary frequency		Loss of sleep

Check recent studies done for your back:

	Imaging for back	Where was the study done?	When?
	Regular X-Rays		
	CAT Scan		
	MRI		
	Bone Scan		
	Myelogram		
	EMG/Nerve Studies		
	Discogram		
	Laboratory Studies		

Patient Name_____**Date of Birth**_____**Patient#**_____

Below, mark the Treatment and the Effect of Treatment. If you tried other treatment not mentioned, write them in on the bottom and their effect.

Treatment	Helped	Worsened	No Change
_____ Physical Therapy _____#weeks	_____	_____	_____
_____ Hot/Cold Pack	_____	_____	_____
_____ Exercise	_____	_____	_____
_____ Bed rest	_____	_____	_____
_____ TENS unit for home use	_____	_____	_____
_____ Massage	_____	_____	_____
_____ Chiropractic _____ #visits	_____	_____	_____
_____ Osteopathic manipulation	_____	_____	_____
_____ Biofeedback	_____	_____	_____
_____ Local (trigger point) injection	_____	_____	_____
_____ Epidural injection How many? ____	_____	_____	_____
_____ Facet joint injection	_____	_____	_____
_____ Pelvic traction	_____	_____	_____
_____ Soft back brace	_____	_____	_____
_____ Rigid back brace	_____	_____	_____
_____ Acupuncture	_____	_____	_____
_____ Aspirin	_____	_____	_____
_____ Tylenol	_____	_____	_____
_____ Motrin, Advil, or other NSAIDS	_____	_____	_____
_____ Pain killers (how often?_____)	_____	_____	_____
_____ Steroid dose pack	_____	_____	_____
_____ Muscle relaxant medication	_____	_____	_____
_____ Anti-depressant medication	_____	_____	_____
_____ Lyrica/Neurontin	_____	_____	_____
_____ Other:_____	_____	_____	_____

Date_____

Patient Name_____**Date of Birth**_____**Patient #**_____

MODIFIED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

This questionnaire has been designed to give your Healthcare Provider information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by checking the box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but please mark only the line which closely describes your current condition**.**

Personal Care (Washing, Dressing, etc.)

- ☐ I do not have to change the way I wash and dress myself to avoid pain.
- ☐ I do not normally change the way I wash or dress myself even though it causes some pain.
- ☐ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
- ☐ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
- ☐ Because of my pain I am partially unable to wash and dress without help.
- ☐ Because of my pain I am completely unable to wash or dress without help.

Lifting (Skip if you have not attempted lifting since the onset of your low back pain)

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
- ☐ Pain prevents me from lifting heavy weights off of the floor, 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.

Walking

- ☐ I have no pain when walking.
- ☐ I have pain when walking, but can still walk my required normal distances.
- ☐ Pain prevents me from walking long distances.
- ☐ Pain prevents me from walking intermediate distances.
- ☐ Pain prevents me from walking even short distances.
- ☐ Pain prevents me from walking at all.

Sitting

- ☐ Sitting does not cause me any pain.
- ☐ I can only sit as long as I like providing that I have my choice of seating surfaces.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Date_____

Patient Name_____**Date of Birth**_____**Patient#**_____

MODIFIED OSWESTRY LOW BACK PAIN QUESTIONNAIRE, p. 2

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but my pain increases with time.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ I avoid standing because it increases my pain right away.

Sleeping

- ☐ I get no pain when I am in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of my pain, my sleep is only ¾ of my normal amount.
- ☐ Because of my pain, my sleep is only ½ of my normal amount.
- ☐ Because of my pain, my sleep is only ¼ of my normal amount.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and does not increase with pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Traveling

- ☐ I get no increased pain when traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get increased pain when traveling, but it does not cause me to seek alternative forms of travel.
- ☐ I get increased pain when traveling, which causes me to seek alternative forms of travel.
- ☐ My pain restricts all forms of travel except that which is done while I am lying down.
- ☐ My pain restricts all forms of travel.

Employment/Homemaking

- ☐ My normal job/homemaking activities do not cause pain.
- ☐ My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming, etc.)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

SCORE: _____

SF-12v2 Health Survey **Patient Name**_____**Date of Birth**_____**Patient #**_____

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

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1. In general, would you say your health is: (Fill in the circle that best describes your answer.)

Excellent	**Very Good**	**Good**	**Fair**	**Poor**
○	○	○	○	○

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2. The following questions are about activities you might do during a typical day. Does *your health now limit* you in these activities? If so, how much? (Fill in a circle on each line.)

	No, Not Limited At all	**Yes, Limited A Lot**	**Yes, Limited A Little**
A. *Moderate Activities*, such as moving a table pushing a vacuum cleaner, bowling, or playing golf	○	○	○
B. Climbing several flights of stairs	○	○	○

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3. During the past *4 weeks*, how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?*

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
A. *Accomplish less* than you would like	○	○	○	○	○
B. Were you limited in the kind of work or other activities	○	○	○	○	○

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4. During the past *4 weeks*, how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious?)

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
A. *Accomplish less* than you would like	○	○	○	○	○
B. Didn't do work or activities as carefully as usual	○	○	○	○	○

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5. 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	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
○	○	○	○	○

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6. These questions are about how you feel and how things have been with you *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*...

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
A. Have you felt calm and peaceful?	○	○	○	○	○
B. Did you have a lot of energy?	○	○	○	○	○
C. Have you felt downhearted and depressed?	○	○	○	○	○

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7. During the *past 4 weeks*, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
○	○	○	○	○

Patient Signature_____**Date of Birth**_____**Date**_____**Patient #**_____