ORTHO MONTANA

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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
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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 #_____

CERVICAL SPINE DATABASE

Please list the doctors you have seen in the last year relating to your neck 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) Neck pain Left arm pain Right arm 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 neck)

Surgery	Surgeon	Location	Did it help?

Patient Name_____Date of Birth_____Patient #_____

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

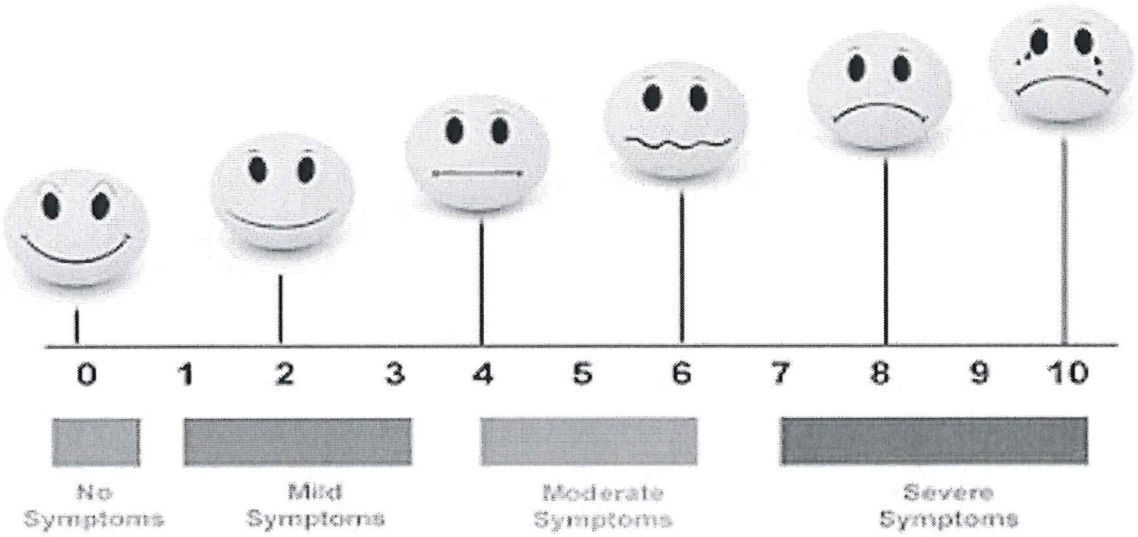
Estimate your walking tolerance in city blocks: _____#blocks and/or_____minutes,_____not limited.

Where is the pain? (mark all that apply)

	Between the shoulder blades		Thumb side of forearm
	Shoulder		Little finger side of forearm
	Biceps		Thumb
	Triceps		Index finger
	Top of forearm		Little finger

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.*

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

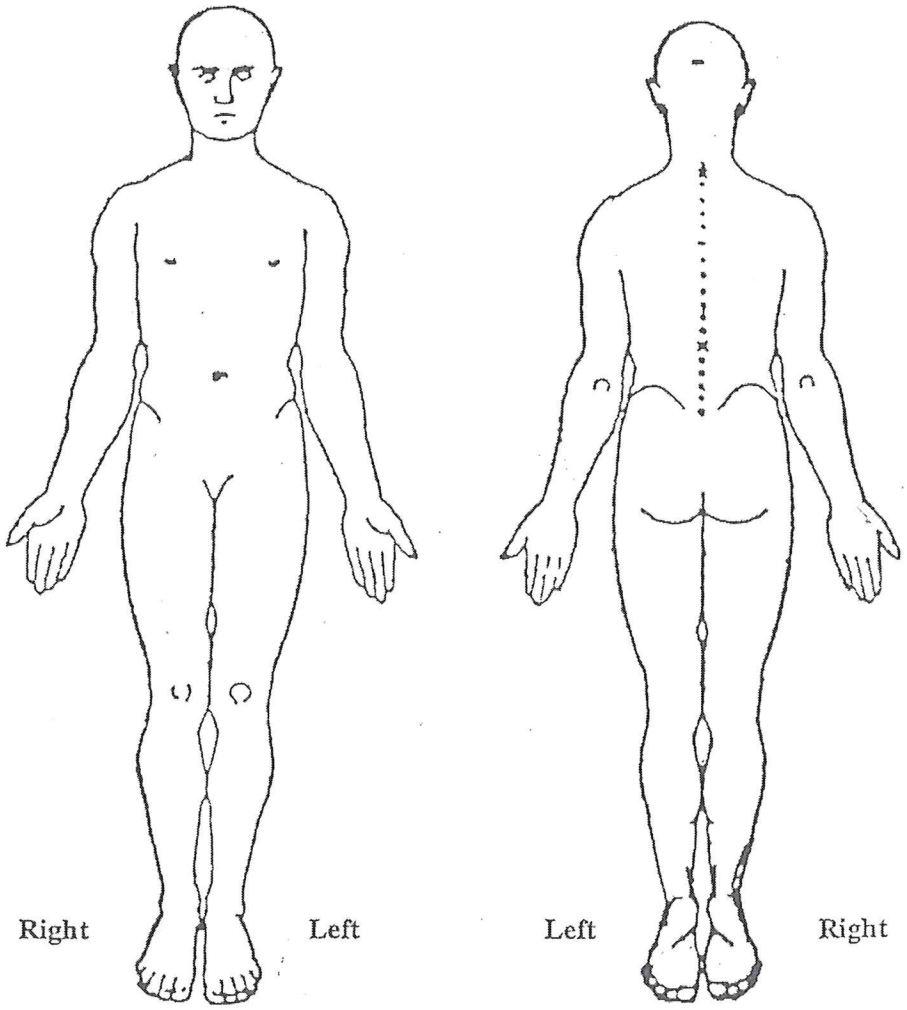
Patient Name_____

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
ORTHO MONTANA

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)

	Changing position		Looking down
	Lying down		Looking up
	Arms positioned overhead		Looking left
			Looking right

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

	Lifting		Looking down
	Coughing or sneezing		Looking up
	Using Shoulder		Looking left
			Looking right

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

	Night Pain		Unexplained weight loss
	Loss of sleep		Frequent headaches
	Grinding in the neck		Pain between the shoulder blades
	Chest muscle pain		Bowel or Bladder changes

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:_____	_____	_____	_____

Patient Name_____Date of Birth_____Patient #_____

NECK DISABILITY INDEX (NDI)

This questionnaire has been designed to give your health care provider information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem today.

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 dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

□ I can lift heavy weights without 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, for example on a table
□ Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
□ I can lift very light 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 at 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 in-frequently
□ I have moderate headaches which come in-frequently
□ I have moderate headaches which come frequently
□ I have severe headaches which come frequently
□ I have headaches almost all of 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 concentration 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 neck pain.
□ I can drive my car as long as I want with moderate neck pain.
□ 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

□ 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 sleep.
□ Pain prevents me from sleeping at all.

Section 10 - Recreation

□ 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.

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#**_____