# ORTHO MONTANA


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**THE TRAUMA CENTER**
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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 #_____

# PEDIATRIC DEFORMITY DATABASE

Please List the doctors you have seen in the last year relating to your back pain.

| Type of Doctor | Doctors Name | Location (city/town) |
|---|---|---|
| Chiropractor | | |
| Neurologist | | |
| Internist/Family | | |
| Surgeon | | |
| Physiatrist (Rehab) | | |
| Pain Clinic Doctor | | |

**History of Present Illness**

What kind of spinal deformity have you noticed?

When was it first noticed?

Previous spine surgeries (only on back)

| Surgery | Surgeon | Location | Did it help? |
|---|---|---|---|

**Birth History**

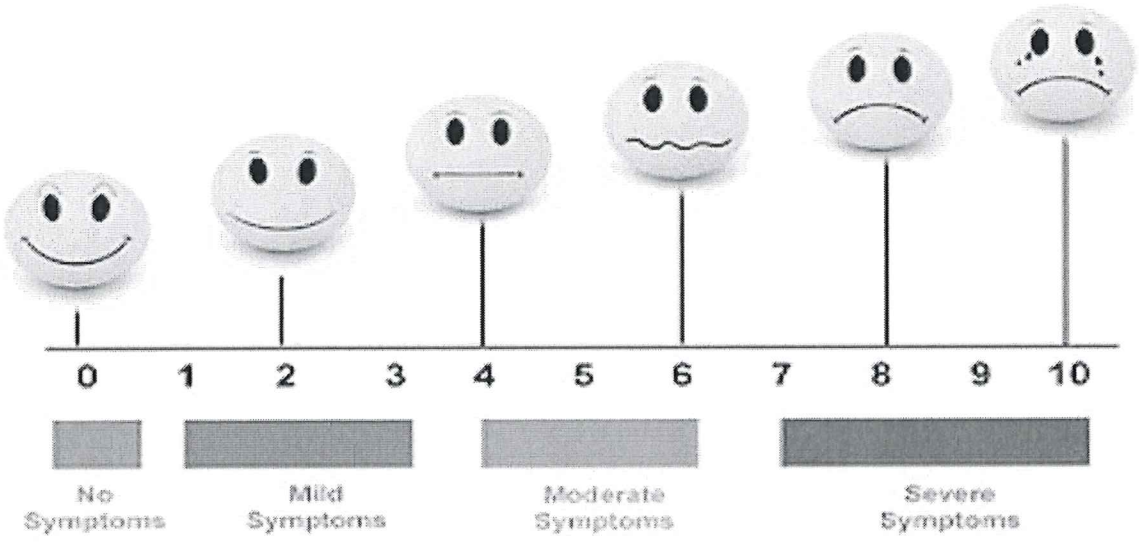
Any Complications?

Normal birth? Y / N

Do you have headaches? Y / N

Do you have back or neck pain? Y / N

# 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.

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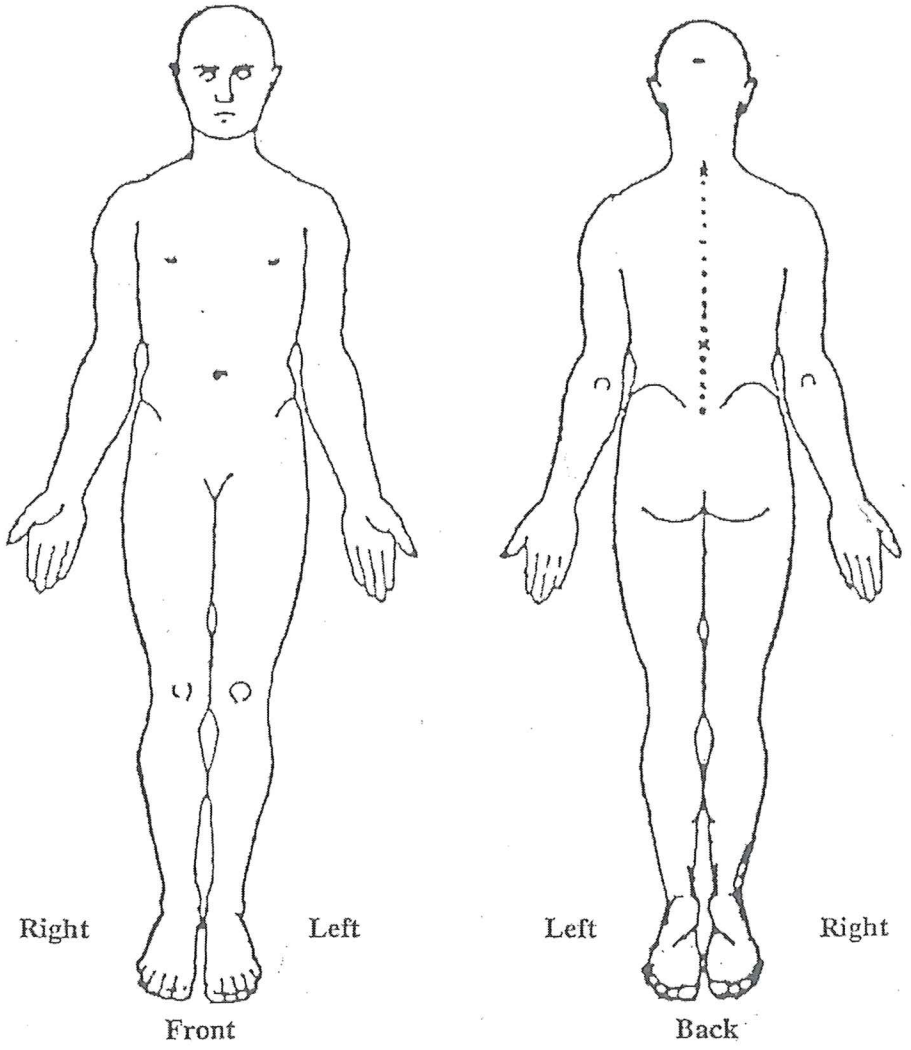
**Patient Name**_____

**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 |

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**Patient Name**_____

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

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 | | |

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:_____ | _____ | _____ | _____ |