

# SALT LAKE ORTHOPAEDIC CLINIC

E. MARC MARIANI, M.D. • MICHAEL H. BOURNE, M.D. • J. ERIC VANDERHOOF, M.D.  
 JOEL T. DALL, M.D. • BRUCE G. EVANS, M.D. • STEVEN M. SCOTT, M.D. • PETER J. NOVAK, M.D.  
 BRENT A. FELIX, M.D. • BRUCE Y. NEWTON, M.D. • ROBERT B. BOURNE, M.D. • CHRISTOPHER H. MARTIN, M.D.  
 KADE T. HUNTSMAN, M.D. • GREGORY S. ANDERSON, D.P.M. • SCOT W. RUSSELL, Ph.D.

Date: \_\_\_\_\_

Account Number: \_\_\_\_\_

Please complete and return this form to the receptionist. Please read and sign the reverse side. **Ref: Physician** \_\_\_\_\_  
**We will file with your insurance company if you supply us with complete insurance information.**

PATIENT INFORMATION			
Patient's Name (First, Middle, Last)			
Patient's Address			
City	State	Zip	
Date of Birth	Age	Sex	Soc. Sec. No.
Home Phone	Work Phone	Marital Status	
Employer			
Employer's Address (Street)			
City	State	Zip	
Occupation (Indicate if Student)		Number of Children	
Nearest Relative/Friend (local, not in same household)			
Nearest Relative's/Friend's Address			
Phone			
City	State	Zip	
FILL IN FOR HUSBAND OR WIFE			
Spouse's Name			
Employer		Phone	
Employer's Address		City	State Zip
FILL IN IF PATIENT IS A MINOR			
Parent's Name (First, Middle, Last)			
Employer			
Employer's Phone			
Employer's Address			
City	State	Zip	
Parent's Name (First, Middle, Last)			
Employer			
Employer's Phone			
Employer's Address			
City	State	Zip	

INSURANCE			
Primary Insurance		Phone	
Name of Policyholder			
Insurance Address (City, State, Zip)			
Date Last Worked		Date Returned to Work	
Policy Number		Group Number	
Secondary Insurance		Group Number	
Name of Policyholder		Policy Number	
Insurance Address (City, State, Zip)			
Reason for Visit		Date of Injury	
INDUSTRIAL			
Employer at Time of Injury		Phone	
Street Address		City	State Zip
Claim Number		Reported Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Injury		Date Last Worked	Date Returned to Work
State Accident Occurred		County Accident Occurred	
Industrial Insurance Carrier			
Street Address		City	State Zip
Type of Injury			
AUTO RELATED?			
Automobile Insurance			
Claim Number			
Street Address		City	State Zip
Name of Insured			
Date of Accident		State of Accident	
Date Last Worked		Date Returned to Work	
Type of Injury			

# The Salt Lake Orthopaedic Clinic (SLOC) Financial Policy

Patient Name \_\_\_\_\_

It is our office policy to inform you of our patient payment procedures. SLOC bills insurance as a courtesy. **The contract you have with your insurance is between you and your insurance carrier. That insurance contract is not between your carrier and SLOC.**

**Please review the sections below.**

## 1. Patient with Insurance

You are responsible for deductibles, co-pays, non-covered services, co-insurance, and items considered "not a covered benefit" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent." If you or your insurance carrier make payments exceeding your balance reimbursement will be remitted. If payment cannot be made at each visit, notify the account coordinator so that other arrangements can be made. **It is the responsibility of the patient to determine that the physician you see is a participating provider on your insurance plan. If your physician is not a participating provider, if you are ineligible for insurance, or have given erroneous information, you will be responsible for the balance.**

## 2. Workers' Compensation Patient

As a Workers' Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment.

**Patient is ultimately responsible for balance.**

## 3. Personal Injury (Accident)

If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. **Patient is ultimately responsible for balance.**

## 4. Medicare/Medicaid

Our office will submit your Medicare/Medicaid charges to Medicare/Medicaid and your secondary insurance. Patient hereby agrees to be responsible for deductibles, co-pays, and any non-covered services.

## 5. Return Check Charges

A return check handling charge of \$20.00 will be applied to all returned checks.

## 6. Interest Rate

You are responsible for payment of your bill. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of \$0.50 per month.

## 7. Forms

There will be a \$20.00 charge for any type of form (excluding Work Comp. Form 123)

**ATTORNEY'S FEES AND COSTS: If any legal action is necessary to enforce the terms of this Agreement, or if it is necessary to employ the services of an attorney, the Patient agrees to pay the Clinic's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled. If Patient fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of this Agreement, Patient agrees to pay the collection expense incurred by SLOC in attempting to collect such amounts from Patient, in addition to the aforementioned attorney's fees and costs.**

## RELEASE OF INFORMATION ASSIGNMENT

\_\_\_\_\_ I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Salt Lake Orthopaedic Clinic for any service furnished me by SLOC.

\_\_\_\_\_ The Signature below authorizes payment of mandated Medigap benefits to SLOC.

\_\_\_\_\_ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to receive.

\_\_\_\_\_ I authorize SLOC to release my protected health information for treatment, payment, or operations as defined by HIPPA laws.

X \_\_\_\_\_  
Patient or responsible party signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person signing on behalf of patient (print name)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness



## Review of Systems

Are you currently having or have you had problems with:

### **General or Constitutional**

	<b>Circle</b>	
High blood pressure	No	Yes
Skin problems	No	Yes
Recent exposure to communicable diseases	No	Yes
Malignant hyperthermia with anesthesia	No	Yes
Blood relative with malignant hyperthermia with anesthesia	No	Yes
Pulmonary embolism	No	Yes
Blood clots in legs	No	Yes
Problems with anesthesia	No	Yes

Please describe all **Yes** responses

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### **Eyes**

	<b>Circle</b>	
Severe headaches	No	Yes
Double vision	No	Yes
Legally blind	No	Yes
Macular degeneration	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

Please describe all **Yes** responses

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### **ENT**

	<b>Circle</b>	
Difficult to open mouth sufficiently to interfere with anesthesia	No	Yes
Sinus infections	No	Yes
Balance problems	No	Yes
Hearing loss	No	Yes

Please describe all **Yes** responses

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### **Respiratory**

	<b>Circle</b>	
Tuberculosis	No	Yes
Sleep apnea	No	Yes
Chronic cough	No	Yes
Pneumonia	No	Yes
Wheezing	No	Yes
Shortness of breath	No	Yes
Emphysema	No	Yes
Abnormal chest x-ray	No	Yes

Please describe all **Yes** responses

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**Cardiovascular**

	<b>Circle</b>	
History of rheumatic fever	No	Yes
Heart murmur	No	Yes
Chest pain	No	Yes
Heart attack	No	Yes
Irregular heartbeat	No	Yes
Ankle swelling	No	Yes
Valve replacement	No	Yes
Congestive heart failure	No	Yes

Please describe all **Yes** responses

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**GU**

	<b>Circle</b>	
Frequent urination at night	No	Yes
Urinary tract infection	No	Yes
Frequency	No	Yes
Pain/burning with urination	No	Yes
Kidney stones	No	Yes

Please describe all **Yes** responses

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**GI**

	<b>Circle</b>	
Jaundice or hepatitis	No	Yes
Stomach ulcers	No	Yes
Hiatal hernia	No	Yes
Reflux	No	Yes
Heartburn	No	Yes
Blood in stools	No	Yes
Irritable bowel syndrome	No	Yes
Diverticulosis	No	Yes
History of bowel obstruction	No	Yes
Hemorrhoids	No	Yes

Please describe all **Yes** responses

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**Neurologic**

	<b>Circle</b>	
History of polio	No	Yes
Stroke	No	Yes
Seizures	No	Yes
Neurological problems	No	Yes
Mental health/phobias including anxiety, depression, psychosis, confusion, memory loss	No	Yes
Multiple sclerosis	No	Yes

Please describe all **Yes** responses

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**Orthopaedic**

- Back problems
- Muscle disorders
- Fibromyalgia
- Fracture of neck or spine
- Arthritis of other joints including hands, wrists, shoulders, elbows, feet, ankles, hips, and knees
- Rheumatoid arthritis
- Gout
- Pseudogout

**Circle**

- |    |     |
|----|-----|
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |

Please describe all **Yes** responses

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**Endocrine**

- Hypoglycemia (low blood sugar)
- Thyroid problems
- Diabetes

**Circle**

- |    |     |
|----|-----|
| No | Yes |
| No | Yes |
| No | Yes |

Please describe all **Yes** responses

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**Hematologic/Immunologic**

- Hemophilia
- Transfusion problems
- Bleeding tendency
- History of any cancer diagnosis
- Anemia

**Circle**

- |    |     |
|----|-----|
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |
| No | Yes |

Please describe all **Yes** responses

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**Other medical problems/comments:**

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Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ SS#: \_\_\_\_\_

### Past Medical History

Surgeries/Hospitalizations	Year	Reason

Have you ever had general anesthesia? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Have any problems with anesthesia? \_\_\_\_\_ No \_\_\_\_\_ Yes Describe: \_\_\_\_\_

### Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

### Social History

\_\_\_\_\_ Work in the home \_\_\_\_\_ Employed (occupation \_\_\_\_\_) \_\_\_\_\_ Student  
\_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed  
Children \_\_\_\_\_ No \_\_\_\_\_ Yes # \_\_\_\_\_  
Do you live alone? \_\_\_\_\_ No \_\_\_\_\_ Yes  
Exercise? \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Rarely \_\_\_\_\_ Never  
What type of exercise? \_\_\_\_\_  
Are you on a special diet? \_\_\_\_\_ No \_\_\_\_\_ Yes Describe \_\_\_\_\_  
History of substance abuse? \_\_\_\_\_ No \_\_\_\_\_ Yes What? \_\_\_\_\_  
Smoke currently? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.  
Quit smoking? \_\_\_\_\_ This year \_\_\_\_\_ 1 year \_\_\_\_\_ 5 years \_\_\_\_\_ 10 years  
Previously smoked \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.  
Drink alcohol? \_\_\_\_\_ Daily \_\_\_\_\_ 1-2x/week \_\_\_\_\_ 1-2x/month \_\_\_\_\_ 1-2x/year

Reviewed By: \_\_\_\_\_ MD Date: \_\_\_\_\_

**Salt Lake Orthopaedic Clinic**  
**Brent A. Felix, M.D.**  
**Low Back Triage Form**

Date: \_\_\_\_\_ SSN#: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance: 1. Private Insurance \_\_\_\_\_  
2. Workers' Compensation \_\_\_\_\_  
3. Motor Vehicle Accident \_\_\_\_\_

How did you hear about the Salt Lake Orthopaedic Clinic?

1. Referred by Doctor \_\_\_\_\_
2. Referred by Emergency Room or Hospital Clinic \_\_\_\_\_
3. Referred by patient of Salt Lake Orthopaedic Clinic \_\_\_\_\_
4. Referred by Other \_\_\_\_\_
5. Referred by Self \_\_\_\_\_

1. How old are you? \_\_\_\_\_

2. Are you:

- a. Male
- b. Female

3. Where is your pain?

- a. Low back
- b. Low back and right leg
- c. Low back and left leg
- d. Low back and both legs

4. How long have you had your pain?

- a. A few days
- b. Several weeks
- c. Several months
- d. Several years

5. Is your pain

- a. Intermittent
- b. Constant

6. Has your pain been

- a. Getting worse
- b. Stayed the same
- c. Getting better



7. Where is the pain in your leg?

- a. Entire leg
- b. Back of the leg
- c. Outside of the leg
- d. Inside of the leg
- e. Front of the leg
- f. None

8. How far down your leg does the pain go?

- a. Buttock
- b. Thigh
- c. Calf
- d. Foot
- e. Doesn't apply to me

9. If the pain goes into your foot, in which part of your foot does it go?

- a. Entire foot
- b. Top
- c. Bottom
- d. Inside
- e. Outside

10. How did your pain begin?

- a. Slow gradual onset
- b. Sudden onset

11. What were you doing at the time your pain began?

- a. Household activities such as vacuuming, raking, child care, etc.
- b. Lifting/bending at work
- c. After falling
- d. In a motor vehicle accident
- e. While playing sports
- f. Of unknown cause

12. From 0 to 10 (0 being no pain and 10 being excruciating pain), what is the average level of your back pain in the last few days?\_\_\_\_

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13. From 0 to 10 (0 being no pain and 10 being excruciating pain), what is the average level of your leg pain in the last few days?\_\_\_\_

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14. What percent of your pain is in your back versus your leg?

	Back pain	vs.	Leg pain
a.	100%		0%
b.	90%		10%
c.	80%		20%
d.	70%		30%
e.	60%		40%
f.	50%		50%
g.	40%		60%
h.	30%		70%
i.	20%		80%
j.	10%		90%
k.	0%		100%

15. Is the pain worse with

- a. Standing
- b. Sitting
- c. Walking
- d. Laying down

16. Is the pain best with
- Standing
  - Sitting
  - Walking
  - Laying down
17. What activities make your pain worse?
- Coughing and sneezing
  - Bending forward
  - Lifting
  - Lying down
  - Any activity in general
18. Do you have numbness in your leg?
- No numbness in your leg
  - Numbness in the same distribution as the pain
  - Numbness in the back of the leg
  - Numbness in the front of the leg
  - Numbness in the inside of the leg
19. Do you have numbness in your foot?
- No numbness in the foot
  - Numbness in the same distribution as the pain
  - Numbness in the entire foot
  - Numbness in the top of foot
  - Numbness in the outside of foot
  - Numbness in the inside of foot
  - Numbness in the bottom of foot
20. Do you have weakness in your leg?
- No weakness
  - Weakness in the entire leg
  - Weakness in the hip
  - Weakness in the knee
  - Weakness in the ankle
21. Have you had changes in your bowel and bladder habits?
- No change in bowel and bladder habits
  - Increased frequency in urination
  - Constipation
  - Diarrhea
  - Difficulty controlling urine/stool
22. Have you tried bed rest for your pain?
- No
  - Yes

23. Which pain medications have you tried for your pain?

- a. No pain medications
- b. Lortab
- c. Percocet
- d. Advil/Motrin/ibuprofen
- e. Naprosyn
- f. Ultram
- g. Oxycontin
- h. Tylenol #3
- i. Darvocet
- j. Relafen
- k. Celebrex
- l. Vioxx
- m. Tylenol
- n. Soma
- o. Flexeril
- p. Valium
- q. Other

24. When was the last time you visited a physical therapist for your back pain?

- a. Have never visited a physical therapist for this back/leg pain
- b. A few days ago
- c. Several weeks ago
- d. Several months ago
- e. Years ago

25. How many times have you visited a physical therapist for your back/leg pain?

- a. Never visited a physical therapist
- b. 1-2
- c. About 5-10
- d. About 10-20
- e. Over 20

26. How many times have you visited a chiropractor for this pain?

- a. No visits
- b. 1-2 visits
- c. About 5-10 visits
- d. About 10-20 visits
- e. Over twenty

27. Have you tried acupuncture?

- a. Not tried
- b. Tried

28. How many epidural steroid injections have you tried?

- a. 1 epidural injection
- b. 2 epidural injections
- c. 3 epidural injections
- d. 4 epidural injections
- e. More than 5 epidural injections
- f. Zero

29. What other treatments have you tried?

- a. Facet injections
  - b. Trigger point injections
  - c. Nerve root injections
  - d. Massage therapy
  - e. TENS unit
  - f. Other \_\_\_\_\_
  - g. No other treatment
-

30. What other studies have you had done?

- a. Bone scan
- b. CT scan
- c. Myelogram
- d. EMG
- e. MRI
- f. X-rays
- g. Blood work

31. How many previous low back surgeries have you had?

- a. Zero
- b. 1
- c. 2
- d. 3
- e. Other \_\_\_\_\_

32. What, if any, previous back surgery have you had?

- a. No previous surgery
- b. A previous discectomy
- c. Laminectomy/decompression
- d. Lumbar fusion
- e. Other \_\_\_\_\_
- f. Unknown

33. If you have had previous back surgery, when was your last back surgery?

- a. No previous surgery
- b. Less than a year go
- c. 1-2 years ago
- d. A few years ago
- e. Over 10 years ago

34. Did the surgery help with your symptoms?

- a. No previous surgery
- b. No help at all
- c. Helped for a short period of time
- d. Helped for quite a while
- e. Not applicable

### Medical History

Please place a check by any illness that you have had.

\_\_\_\_\_ Heart murmur  
\_\_\_\_\_ Heart attack  
\_\_\_\_\_ Other heart disease  
\_\_\_\_\_ High blood pressure  
\_\_\_\_\_ Blood transfusion  
\_\_\_\_\_ Phlebitis  
\_\_\_\_\_ Thyroid disorder  
\_\_\_\_\_ Venereal disease  
\_\_\_\_\_ Nervous disorder  
\_\_\_\_\_ Hepatitis  
\_\_\_\_\_ Fibromyalgia  
\_\_\_\_\_ Migraine headaches

\_\_\_\_\_ Gout  
\_\_\_\_\_ Pneumonia  
\_\_\_\_\_ Emphysema  
\_\_\_\_\_ Allergies (hayfever)  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Epilepsy  
\_\_\_\_\_ Anemia  
\_\_\_\_\_ Tuberculosis  
\_\_\_\_\_ Tumor  
\_\_\_\_\_ Jaundice  
\_\_\_\_\_ TMJ pain  
\_\_\_\_\_ Anxiety

\_\_\_\_\_ Glaucoma  
\_\_\_\_\_ Bleeding disorder  
\_\_\_\_\_ Kidney/Bladder  
\_\_\_\_\_ If yes, what \_\_\_\_\_  
\_\_\_\_\_ Ulcer (peptic, duodenal)  
\_\_\_\_\_ Arthritis  
\_\_\_\_\_ Diabetes  
\_\_\_\_\_ If yes, how long \_\_\_\_\_  
\_\_\_\_\_ Cancer  
\_\_\_\_\_ If yes, what type \_\_\_\_\_  
\_\_\_\_\_ Depression  
\_\_\_\_\_ Other \_\_\_\_\_

### Surgical History

Please place a check by each surgery that you have had.

- |  |   |
|--|---|
| <input type="checkbox"/> Neck surgery          | <input type="checkbox"/> Prostate removed |
| <input type="checkbox"/> Back surgery          | <input type="checkbox"/> Cosmetic surgery |
| <input type="checkbox"/> Open heart surgery    | <input type="checkbox"/> Colon surgery    |
| <input type="checkbox"/> Heart angioplasty     | <input type="checkbox"/> Lung surgery     |
| <input type="checkbox"/> Gall bladder removed  | <input type="checkbox"/> Hip replacement  |
| <input type="checkbox"/> Appendectomy          | <input type="checkbox"/> Knee replacement |
| <input type="checkbox"/> Hysterectomy          | <input type="checkbox"/> Knee arthroscopy |
| <input type="checkbox"/> Carpal tunnel release | <input type="checkbox"/> Kidney surgery   |
| <input type="checkbox"/> Shoulder surgery      |   |
| <input type="checkbox"/> Other _____           |   |

### Medications

Medication	Number of milligrams	How often

Do you have any drug allergies?

- a. No
- b. Yes

If yes, to which drugs do you have an allergy? Please list.

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### Family History

Relative	Medical problems	Alive or deceased	Cause of death
Mother			
Father			
Brother			
Sister			
Grandparents			

How much do you smoke?

- a. None
- b. 1/2 pack per day
- c. 1 pack per day
- d. 1 1/2 packs per day
- e. 2 or more packs per day

How much alcohol do you drink?

- a. None
- b. Almost every day
- c. Once per week
- d. Once per month
- e. Rarely

### Work Status

What is your present work status?

1. Full duty
2. Part time
3. Light duty
4. Disabled
5. Unemployed
6. Retired

Date last worked? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

What is the average weight of objects that you have to lift at work?

1. 1-25 lbs
2. 25-50 lbs
3. 50-75 lbs
4. 75-100 lbs
5. 100 lbs or more

How frequently are you required to lift daily?

1. Rarely
2. Occasionally
3. Frequently
4. Constantly

Are you presently receiving:

Workers' compensation	Yes _____	No _____
Social Security	Yes _____	No _____
Private disability	Yes _____	No _____

Are you involved in a personal lawsuit? Yes \_\_\_\_\_ No \_\_\_\_\_

## Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**. Please explain any of the Yes answers in the spaces provided.

### Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	_____	

### Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other	_____	

### Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other	_____	

### Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other	_____	

### Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other	_____	

### Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other	_____	

### Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other	_____	

### Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	_____	

### Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other	_____	

### Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other	_____	

### Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other	_____	

### Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N
Other	_____	

### Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other	_____	

### Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other	_____	

Any other conditions that we should be aware of?

**PHYSICIANS USE ONLY: (COMMENTS/NOTES)**

Physician: \_\_\_\_\_

Date: \_\_\_\_\_



# OSWESTRY LOW BACK PAIN QUESTIONNAIRE

This questionnaire gives your doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box which applies to you. Please circle one number

- Section 1- PERSONAL CARE (WASHING, DRESSING, ETC.)
- 0 ( ) I can look after myself normally without causing 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 2- LIFTING
- 0 ( ) I can lift heavy objects without extra pain.
  - 1 ( ) I can lift heavy objects but it gives me extra pain.
  - 2 ( ) Pain prevents me from lifting heavy objects off the floor, but can manage if they are positioned on a table.
  - 3 ( ) Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
  - 4 ( ) I can only lift very light objects.
  - 5 ( ) I cannot lift or carry anything at all.

- Section 3- WALKING
- 0 ( ) Pain does not prevent me from walking any distance.
  - 1 ( ) Pain prevents me from walking more than 1 hour.
  - 2 ( ) Pain prevents me from walking more than 30 minutes.
  - 3 ( ) Pain prevents me from walking more than 10 minutes.
  - 4 ( ) I can only walk a few steps.
  - 5 ( ) I am unable to walk.

- Section 4- SITTING
- 0 ( ) I can sit in any chair as long as I like.
  - 1 ( ) I can only sit in my favorite chair as long as I like it.
  - 2 ( ) Pain prevents me from sitting for more than 1 hour.
  - 3 ( ) Pain prevents me from sitting for more than 30 minutes.
  - 4 ( ) Pain prevents me from sitting for more than 10 minutes.
  - 5 ( ) Pain prevents me from sitting at all.

- Section 5- STANDING
- 0 ( ) I can stand as long as I want without extra pain.
  - 1 ( ) I can stand as long as I want but it give me extra pain.
  - 2 ( ) Pain prevents me from standing for more than 1 hour.
  - 3 ( ) Pain prevents me from standing for more than 30 minutes.
  - 4 ( ) Pain prevents me from standing for more than 10 minutes.
  - 5 ( ) Pain prevents me from standing at all.

- Section 6- SLEEPING
- 0 ( ) I sleep well.
  - 1 ( ) Pain occasionally interrupts my sleep.
  - 2 ( ) Pain interrupts sleep half of the time.
  - 3 ( ) Pain often interrupts my sleep.
  - 4 ( ) Pain always interrupts my sleep.
  - 5 ( ) I never sleep well.

- Section 7- SEX LIFE
- 0 ( ) My sex life is unchanged.
  - 1 ( ) My sex life is normal and causes some extra pain.
  - 2 ( ) My sex life is nearly normal but is very painful.
  - 3 ( ) My sex life is severely restricted by pain.
  - 4 ( ) My sex life is nearly absent because of pain.
  - 5 ( ) Pain prevents any sex life at all.

Section 8-

SOCIAL LIFE

- 0 ( ) My social and recreational life is unchanged.
- 1 ( ) My social and recreational life is unchanged but increases pain.
- 2 ( ) My social and recreational life is unchanged but severely increases pain.
- 3 ( ) Pain has restricted my social and recreational life.
- 4 ( ) Pain has severely restricted my social and recreational life.
- 5 ( ) I have no social life because of pain.

Section 9-

TRAVELING

- 0 ( ) I can travel anywhere without extra pain.
- 1 ( ) I can travel anywhere but it gives me extra pain.
- 2 ( ) Pain is bad but I can manage traveling over 2 hours.
- 3 ( ) Pain restricts me to trips of less than 1 hour.
- 4 ( ) Pain restricts me to trips under 30 minutes.
- 5 ( ) Pain prevents me from traveling.

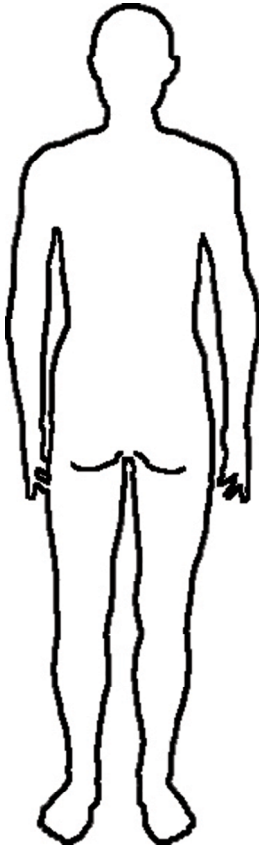
# Patient Pain Drawing

Name: \_\_\_\_\_

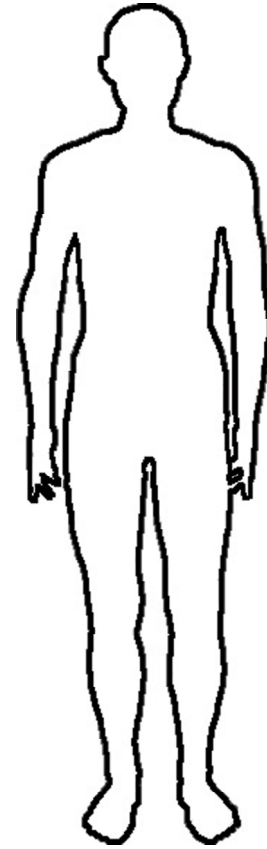
Date: \_\_\_\_\_

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
—	==	●●●	XXX	△△△	○○○



Pain in arm(s)  
compared with neck:  
 \_\_\_Worse than  
 \_\_\_Same as  
 \_\_\_Less than



Pain in leg(s)  
compared with back:  
 \_\_\_Worse than  
 \_\_\_Same as  
 \_\_\_Less than

ACTIVITIES: Is your pain aggravated by any of these?

- \_\_\_\_\_ coughing or sneezing
- \_\_\_\_\_ sitting in a chair
- \_\_\_\_\_ bending forward to brush teeth
- \_\_\_\_\_ when you wake up

- \_\_\_\_\_ in the middle of the night
- \_\_\_\_\_ lying flat on your back
- \_\_\_\_\_ lying flat on your stomach
- \_\_\_\_\_ walking a distance