SALT LAKE ORTHOPAEDIC CLINIC

E. MARC MARIANI, M.D. • MICHAEL H. BOURNE, M.D. • J. ERIC VANDERHOOFT, 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 ______Yes ______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

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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

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Salt Lake Orthopaedic Clinic
Medical History

Name:________________________________Today's Date:________________SS#:________________

Date of Birth:__________________Age:________Height:________________Weight:________________

Referring Physician:____

Chief Complaint

Why are you seeing the doctor today?____

List any treatment, test, or X-rays you have had for this problem:_____________________________

Current problem is the result of a(n):_____Car accident_____Work Accident_____Other Accident_____NOT Accident Related

Date of Accident	Location (Home, School, Work, etc.)	Details of Accident or Injury

This occurred during: Check all that apply

Lifting	Pulling	Pushing	Twisting	Falling
Reaching	Squatting	Hit by Object	Not Known	Bending

Current Medical Problems:____

____

____

____

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____

Medication:	Dose	Times/Day	How Long

Allergies:____

____

____

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Review of Systems

Are you currently having or have you had problems with:

General or Constitutional	**Circle**	
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

____

____

Eyes	**Circle**	
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

____

____

ENT	**Circle**	
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

____

____

Respiratory	**Circle**	
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

	Circle	
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

____

____

GU

	Circle	
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

____

____

GI

	Circle	
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

____

____

Neurologic

	Circle	
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

	No	**Circle**	Yes
Back problems	No		Yes
Muscle disorders	No		Yes
Fibromyalgia	No		Yes
Fracture of neck or spine	No		Yes
Arthritis of other joints including hands, wrists, shoulders, elbows, feet, ankles, hips, and knees	No		Yes
Rheumatoid arthritis	No		Yes
Gout	No		Yes
Pseudogout	No		Yes

Please describe all **Yes** responses

___

___

Endocrine

	No	**Circle**	Yes
Hypoglycemia (low blood sugar)	No		Yes
Thyroid problems	No		Yes
Diabetes	No		Yes

Please describe all **Yes** responses

___

___

Hematologic/Immunologic

	No	**Circle**	Yes
Hemophilia	No		Yes
Transfusion problems	No		Yes
Bleeding tendency	No		Yes
History of any cancer diagnosis	No		Yes
Anemia	No		Yes

Please describe all **Yes** responses

___

___

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:____________________________

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Salt Lake Orthopaedic Clinic
Brent A. Felix, M.D.
Cervical 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. Neck
   b. Neck and right arm
   c. Neck and left arm
   d. Neck and both arms

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

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7. Where is the pain in your arm?
   a. Entire arm
   b. Back of the arm
   c. Outside of the arm
   d. Inside of the arm
   e. Front of the arm
   f. None

8. How far down your arm does the pain go?
   a. Shoulder
   b. Elbow
   c. Wrist
   d. Hand
   e. Doesn't apply to me

9. If the pain goes into your hand, in which part of your hand does it go?
   a. Entire hand
   b. Thumb
   c. Index finger
   d. Middle finger
   e. Ring finger
   f. Small finger

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 neck pain in the last few days?___

____

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

____

14. What percent of your pain is in your neck versus your arm?

	Neck pain	vs.	Arm 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

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16. Is the pain best with
    a. Standing
    b. Sitting
    c. Walking
    d. Laying down

17. What activities make your pain worse?
    a. Coughing and sneezing
    b. Bending forward
    c. Lifting
    d. Lying down
    e. Any activity in general

18. Do you have numbness in your arm?
    a. No numbness in your arm
    b. Numbness in the same distribution as the pain
    c. Numbness in the back of the arm
    d. Numbness in the front of the arm
    e. Numbness in the inside of the arm

19. Do you have numbness in your hand?
    a. No numbness in the hand
    b. Numbness in the same distribution as the pain
    c. Numbness in the entire hand
    d. Numbness in the top of hand
    e. Numbness in the outside of hand
    f. Numbness in the inside of hand
    g. Numbness in the bottom of hand

20. Do you have weakness in your arm?
    a. No weakness
    b. Weakness in the entire arm
    c. Weakness in the shoulder
    d. Weakness in the elbow
    e. Weakness in the wrist

21. Have you had changes in your bowel and bladder habits?
    a. No change in bowel and bladder habits
    b. Increased frequency in urination
    c. Constipation
    d. Diarrhea
    e. Difficulty controlling urine/stool

22. Have you tried bed rest for your pain?
    a. No
    b. 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. Other

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24. When was the last time you visited a physical therapist for your neck/arm pain?
    a. Have never visited a physical therapist for this 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 neck/arm 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______________________________

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32. What, if any, previous back surgery have you had?
   a. No previous surgery
   b. A previous discectomy
   c. Laminectomy/decompression
   d. Cervical fusion
   e. Other____________________
   f. Unknown

33. If you have had previous neck surgery, when was it?
   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.

________Neck surgery
________Back surgery
________Open heart surgery
________Heart angioplasty
________Gall bladder removed
________Appendectomy
________Hysterectomy
________Carpal tunnel release
________Shoulder surgery
________Other___________________________________

________Prostate removed
________Cosmetic surgery
________Colon surgery
________Lung surgery
________Hip replacement
________Knee replacement
________Knee arthroscopy
________Kidney surgery

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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.

____

____

____

____

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

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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_____

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o. 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________________________________

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Any other conditions that we should be aware of?

PHYSICIANS USE ONLY: (COMMENTS/NOTES)

Physician:____ Date:_________________________

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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

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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?___

____

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?____

____

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

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16. Is the pain best with
    a. Standing
    b. Sitting
    c. Walking
    d. Laying down

17. What activities make your pain worse?
    a. Coughing and sneezing
    b. Bending forward
    c. Lifting
    d. Lying down
    e. Any activity in general

18. Do you have numbness in your leg?
    a. No numbness in your leg
    b. Numbness in the same distribution as the pain
    c. Numbness in the back of the leg
    d. Numbness in the front of the leg
    e. Numbness in the inside of the leg

19. Do you have numbness in your foot?
    a. No numbness in the foot
    b. Numbness in the same distribution as the pain
    c. Numbness in the entire foot
    d. Numbness in the top of foot
    e. Numbness in the outside of foot
    f. Numbness in the inside of foot
    g. Numbness in the bottom of foot

20. Do you have weakness in your leg?
    a. No weakness
    b. Weakness in the entire leg
    c. Weakness in the hip
    d. Weakness in the knee
    e. Weakness in the ankle

21. Have you had changes in your bowel and bladder habits?
    a. No change in bowel and bladder habits
    b. Increased frequency in urination
    c. Constipation
    d. Diarrhea
    e. Difficulty controlling urine/stool

22. Have you tried bed rest for your pain?
    a. No
    b. Yes

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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

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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___________________

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Surgical History

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

________Neck surgery
________Back surgery
________Open heart surgery
________Heart angioplasty
________Gall bladder removed
________Appendectomy
________Hysterectomy
________Carpal tunnel release
________Shoulder surgery
________Other________________________________

________Prostate removed
________Cosmetic surgery
________Colon surgery
________Lung surgery
________Hip replacement
________Knee replacement
________Knee arthroscopy
________Kidney surgery

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______

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Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o. 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________________________________

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Any other conditions that we should be aware of?

PHYSICIANS USE ONLY: (COMMENTS/NOTES)

Physician:____ Date:_____________________________

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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 fore 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.

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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.

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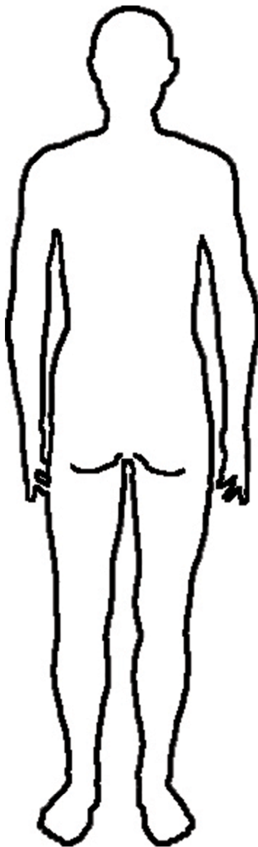
Patient Pain Drawing

Name:____ Date:__________________________________

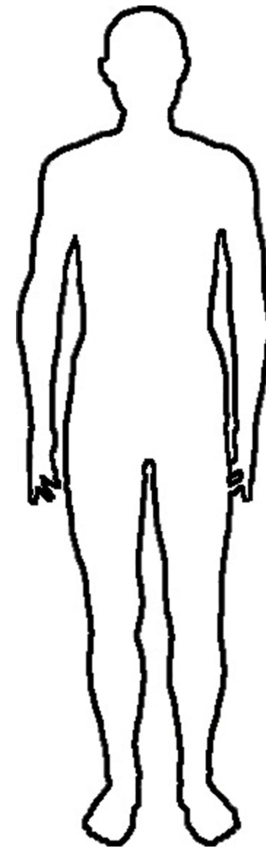
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
———	═══	● ● ●	XXX	Δ Δ Δ	○ ○ ○



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

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