Community Health Network

On behalf of the Community Spine Center team, we would like to welcome you. At the Community Spine Center we strive to give our patients exceptional, state-of-the-art care. Although we have received the national recognition for excellence from the National Committee of Quality Assurance, we are only as good as the treatment we provide to our current and future patients such as you.

We will try to make your treatment as helpful as possible, but we will need your active participation. As part of our assessment of your progress we will need you to complete paperwork at each visit with the doctor. This reassessment is crucial for us and gives us the tools we need to help you more; it is also a requirement to continue to be recognized as a national leader in spine care.

We strive to continue a high level of evidence-based care and excellence in the treatment of neck and back pain. Patient input is extremely valuable, so we look forward to open and direct communication with you.

If you have any questions after reviewing this, please do not hesitate to call our office. We ask that you bring the enclosed folder with you to your appointments so you have a place to store additional information we may provide to you during your care with us. Please complete the enclosed paperwork and bring it with you to your appointment. This information, filled out in advance, assists us in focusing your first visit to be as productive as possible.

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Please visit our website at www.eCommunity.com/spine for more information.

Recognition for superior care

Please list any known ALLERGIES and your REACTION:

_____

_____

Please list any medications you are currently taking:

Medication Name	Dosage

Please provide name and major cross streets of your preferred pharmacy:

_____

_____

Patient Surgical History – Please circle all that apply:

Appendix
Breast Biopsy
Fracture Repair
Gallbladder
Joint Arthroscopy
Open Heart Surgery
Neck Surgery
Back Surgery
Joint Replacement

Other surgeries not listed above: _____

_____

Patient Medical History – Please circle all that apply:

Anxiety/Depression	High blood pressure
Asthma	HIV
Bladder infections	Irritable bowel
Bleeding disorder	Kidney disease
Blood clots	Lung disease
Cancer	Lupus
Chronic fatigue syndrome	Mitral valve prolapse
Degenerative muscle/nerve disease	Multiple sclerosis
Diabetes	Pacemaker
Dialysis	Polio
Diverticulosis	Psychological problems
Fibromyalgia	Reflux
Glaucoma	Rheumatoid arthritis
Gout	Seizures
Heart attic	Sexually transmitted disease
Heart disease	Sleep Apnea
Hemophilia	Stomach ulcers
Hepatitis C	Stroke
Hiatal hernia	Thyroid trouble
TIA	

Other medical history not listed above: _____

_____

_____

Family Medical History – Please mark all that apply:

Family History Unknown	High blood pressure
Alcoholism	High cholesterol
Anemia	Kidney/Bladder disease
Anesthetic problems	Lung/Respiratory disease
Arthritis	Migraines
Asthma	Osteoporosis
Bleeding disease	Seizures/Convulsions
Breast cancer	Severe Allergy/Hives
Colon/Rectal cancer	Stroke/CVA of the brain
Depression	Thyroid problems
Diabetes	Other Cancer
Heart disease	

Other family medical history : _____

_____

Patient Social History – Please indicate as appropriate:

ALCOHOL USE:

Drinks/Week ☐ Glasses of wine
☐ Cans of beer
☐ Shots of liquor

Tobacco Use :

Current Smoker

Packs Per Day_____ How long have you smoked?_____

Former Smoker

Packs Per Day_____ How long did you smoke_____ Year Quit_____

Passive Smoker Yes ☐ NO ☐

Never Smoker Yes ☐

1) Please list any other physicians you've seen for this problem:

NAME	SPECIALTY	YEAR SEEN

****Please circle all that apply****

2) Have you had physical therapy in the past for this problem? *YES *NO

3) If yes, what type of physical therapy interventions:

*stretches *strengthening *ultra sound *cervical traction

*lumbar traction *home exercise *McKenzie *other_____

4) What would you like to do that you cannot currently do because of your symptoms?

_____

_____

5) Tests or procedures I've had for this problem:

*none *x-rays *MRI *CAT Scan *myelogram *bone scan

*discogram *EMG *other_____

Assessment of your pain

1) Date my current episode of pain began:_____

2) Pain onset for my current episode: (Please only select ONE choice)

*awakened from sleep *gradual *on-going *progressive *sudden *unable to tell

3) Describe your pain: (Please circle all that apply)

*aching *burning *constant *cramping *crushing *discomfort *dull *headache

*heaviness *itching *jabbing *nagging *numbness *penetrating

*pins and needles *pounding *pressure *radiating *sharp *shooting *sore

*spasm *squeezing *stabbing *tender *throbbing *tightness

4) How often do you experience pain: (Please circle only ONE choice)

*continuous *rarely *once a week *several days a week *intermittent

*constant/continuous *other_____

5) My pain is worse with: (Please circle all that apply)

*sneeze/cough *bending *lifting *walking *sitting *standing *stretching

*riding in car *straightening *kneeling *squatting *lying down *exercise

*morning *daytime *evening *nighttime *other_____

6) Is your pain a result of an injury? *YES *NO

If yes, please explain_____

7) Is your pain from a work related injury? *YES *NO

Please circle all that apply:

CONSTITUTIONAL	EYES	GASTROINTESTINAL	ENDO/HEME
Fever	Blurred vision	Heartburn	Easy bruise/bleed
Chills	Double vision	Nausea	Allergies
Weight loss	Light sensitivity	Vomiting	**NEUROLOGICAL**
Fatigue	Eye pain	Abdominal pain	Dizziness
Sweats	Eye discharge	Diarrhea	Tingling
Weakness	Eye redness	Constipation	Tremor
SKIN	**CARDIOVASCULAR**	Blood in stool	Sensory change
Rash	Chest pain	**GENITOURINARY**	Speech change
Itching	Palpitations	Painful urination	Focal weakness
HENT	Pain in legs while walking	Bladder urgency	Seizures
Headaches	Leg swelling	Urinating more often	Loss of consciousness
Hearing loss	**RESPIRATORY**	Blood in urine	**PSYCHIATRIC**
Ringing in ears	Cough	Flank pain	Depression
Nosebleeds	Coughing up blood	**MUSCULOSKELETAL**	Suicidal ideas
Congestion	Shortness of breath	Muscle pain	Substance abuse
Sore throat	Wheezing	Neck pain	Hallucinations
		Back pain	Nervous/Anxious
		Joint pain	Insomnia
		Falls	Memory loss

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Back Pain Oswestry Disability

Name:_____ Date:_____

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check **ONLY ONE** answer in each section that best describes your current problem.

Section 1-- **PAIN INTENSITY**

0. The pain is tolerable without using any medication.
1. The pain is bad, but I can manage without having to take pain medication.
2. Pain medication provides me with complete relief from pain.
3. Pain medication provides me with moderate relief from the pain.
4. Pain medication provides me with very little relief from the pain.
5. Pain medication has no effect on my pain.

Section 2-- **PERSONAL CARE**

0. I can take care of myself without causing increased pain.
1. I can take care of myself but it does increase the pain.
2. It is painful to take care of 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 can not get dressed, wash with difficulty and stay in bed.

Section 3—**LIFTING**

0. I can lift heavy weights without pain.
1. I can lift heavy weights but it causes pain.
2. Pain prevents me from lifting anything heavy off the floor, but if they are conveniently positioned, I can manage.
3. Pain prevents me from lifting anything heavy, but I can still manage medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything at all.

Section 4—**WALKING**

0. I have no pain when walking at any distance.
1. I have pain with walking, but it does not increase with distance.
2. Pain prevents me from walking more than 1 mile.
3. Pain prevents me from walking more than 1/2 mile.
4. I have to use a crutch or cane to walk.
5. I am in bed most of the time and have to crawl to the toilet.

Section 5-- **SITTING**

0. I can sit anywhere without pain.
1. I can only sit in a particular chair as long as I would like without pain.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

Section 6—**STANDING**

0. I can stand as long as I want without pain.
1. I can stand as long as I want, but in time, my pain increases.
2. Pain prevents me from standing longer than 1 hour.
3. Pain prevents me from standing longer than 1/2 hour.
4. Pain prevents me from standing longer than 10 minutes.
5. I am not able to stand due to my pain.

Section 7—**SLEEPING**

0. I have no trouble sleeping and have no pain.
1. I can sleep well only by using pain medication.
2. My sleep is slightly disturbed (<1 hr sleepless).
3. My sleep is moderately disturbed. (2 hours sleepless).
4. My sleep is greatly disturbed. (3-5 hours sleepless).
5. Pain prevents me from sleeping at all.

Section 8-- **SOCIAL LIFE**

0. Pain has no effect on my social life.
1. My social life is normal, but increases the degree of my pain.
2. Pain has limited me from my more energetic interests (e.g.,dancing,etc.)
3. Pain prevents me from going out very often.
4. Pain has restricted my social life to my home.
5. I have no social life due to my pain.

Section 9—**TRAVELING**

0. I get no pain while traveling.
1. I can travel but it does cause me extra pain.
2. I have pain, but am able to travel over 2 hours.
3. Pain restricts me to travel less than 1 hour.
4. Pain restricts me to short journeys under 30 minutes.
5. Pain prevents me from traveling except to the doctor or hospital.

Section 10-- **CHANGING DEGREE OF PAIN**

0. My pain is rapidly getting better.
1. My pain fluctuates, but overall is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at the present time.
3. My pain is stable (no better, no worse).
4. My pain is gradually getting worse.
5. My pain is rapidly getting worse

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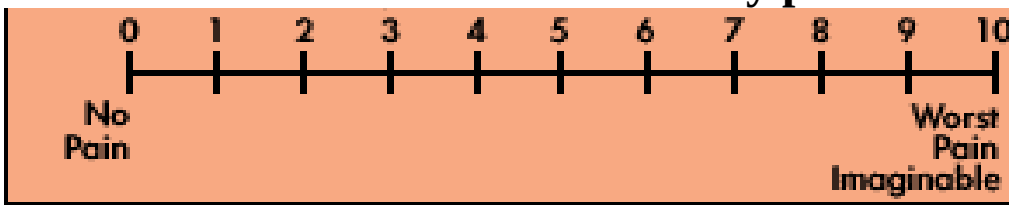
Name:_____ **Date:**_____

1. Most of the time I would rate my pain as:



2.

Please shade in where your pain is located, and place 'x' marks over areas of numbness.