

Welcome to the Community Spine Center

On behalf of the Community Spine Center team, welcome. Our goal is to provide exceptional, evidence-based care for patients with spine and musculoskeletal conditions. The Spine Center has received national recognition for quality from the National Committee for Quality Assurance, and we are committed to maintaining that high standard for every patient we serve.

Your participation plays an important role in your care. As part of your treatment, we ask that you complete brief questionnaires at your visits. These allow us to track your progress over time and ensure that your care plan is helping you improve. Patient-reported information is an important part of delivering high-quality spine care and helps us continually evaluate and improve our program.

We are committed to providing thoughtful, evidence-based treatment for neck and back pain and believe that open communication with our patients is essential. Your feedback and input are always welcome.

Please review and complete the enclosed paperwork prior to your appointment and bring it with you. Having this information in advance allows us to focus your visit on understanding your condition and developing the most appropriate treatment plan.

If you have any questions after reviewing these materials, please feel free to contact our office. We also recommend bringing the enclosed folder to your visits so you can keep any information or instructions provided during your care.

We look forward to partnering with you in your treatment.

Sincerely,

Carrie M. Gould, MD, MBA
Medical Director, Community Spine Centers

Community Spine Center North

Nathan R. Farlow, MD
Nathan B. Kurtz, MD
Kyle J. Mazellan, MD
Jason K. Sorg, MD

Community Spine Center South/East

Carrie M. Gould, MD
Joshua C. Salyer, DO
Nicole R. Zulkowski, MD

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

Recognition for superior care



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 attack | 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
Ringling 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

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.

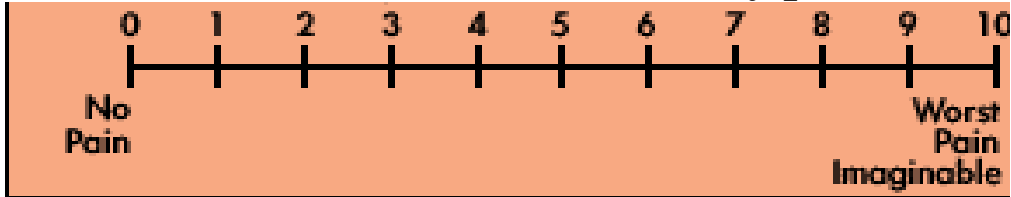
Section 10-- CHANGING DEGREE OF PAIN

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

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.

