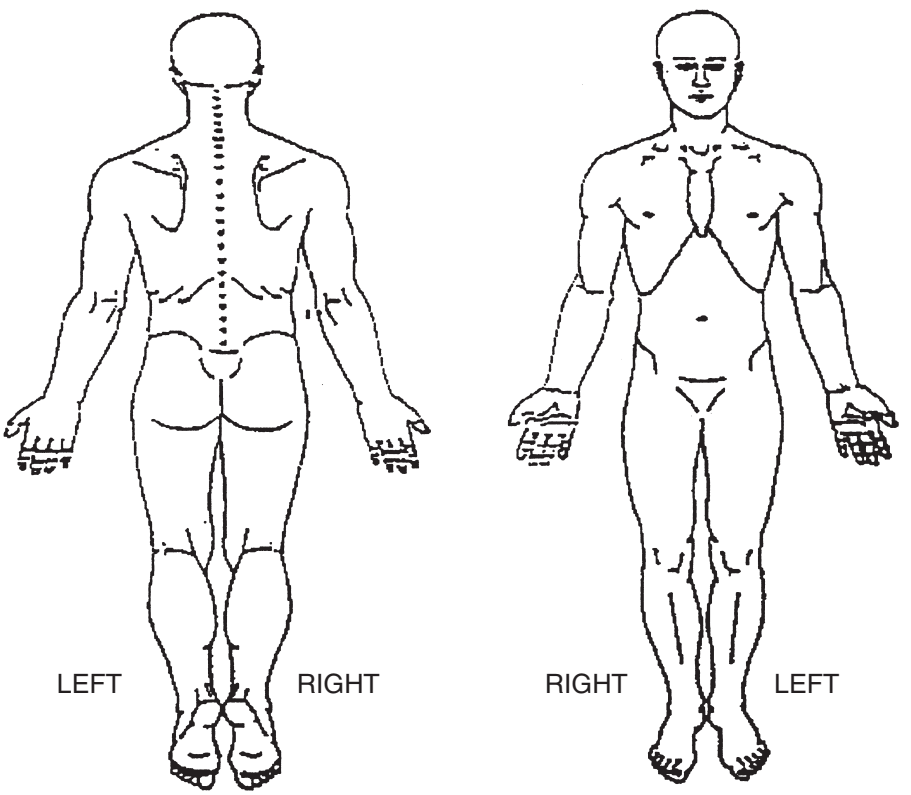
TEXAS HEALTH CARE, P.L.L.C.

PATIENT NAME:	AGE:	ACCOUNT NO.:
DATE OF VISIT:		TIMEPOINT:

Mark these drawings according to where you hurt. If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

Numbness	Burning	Ache	Pins & Needles	Stabbing
========	XXXXXX	^^^^^^^^	OOOOO	//////////////



How would you describe your current pain ratio? (Please check one box)

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
✓	% Back Pain	% Leg Pain	✓	% Neck Pain	% Arm Pain
	100%	0%		100%	0%
	75%	25%		75%	25%
	50%	50%		50%	50%
	25%	75%		25%	75%
	0%	100%		0%	100%

HEIGHT:
WEIGHT:
RADIAL PULSE:

Current Pain Intensity

Please circle the number which best describes your current pain level

(0 represents "no pain") (10 is "the worst pain you could imagine")

Today	0	1	2	3	4	5	6	7	8	9	10
Best Day	0	1	2	3	4	5	6	7	8	9	10
Worst Day	0	1	2	3	4	5	6	7	8	9	10

PATIENT NAME:	ACCOUNT NO.:

Sex: M or F	Age:	Dominant Hand: R or L	Date Your Pain Started:

Which physician referred you to Texas Health Care Orthopedics and Sports Medicine?	Name of Physician Office Address			
What is the main reason for your visit?				
What are your present symptoms?				
Describe how the injury occurred?				
Did you sustain any other injuries at the time of this injury? If yes, please describe.				
Is this injury work related?	❑ Yes	❑ No	❑ Unsure	
Is there an upcoming worker's compensation hearing?	❑ Yes	❑ No	❑ Unsure	
Do you have a lawyer for your injury?	❑ Yes	❑ No	❑ Unsure	
Did an automobile accident cause your pain?	❑ Yes	❑ No	Date of Accident:	
Description of the accident				
Were you wearing a seatbelt?	❑ Yes	❑ No		
Is there upcoming litigation?	❑ Yes	❑ No		
Do you get leg pain as your walk?	❑ Yes	❑ No		
How far can you walk? (check one box)	❑ Less than 1 block	❑ 1 block	❑ 5-10 blocks	❑ more than 1 mile
If you sit down after you walk, does your leg pain get better?	❑ Yes	❑ No		
How long have you had your current pain? (check one box)	❑ Unknown ❑ About 1 Day ❑ About 3 days ❑ About 1 week ❑ About 1 month ❑ About 3 months		❑ About 6 months ❑ About 6 months to 1 year ❑ About 1 to 2 years ❑ About 2 to 3 years ❑ About 3 to 5 years ❑ More than 5 years	

PATIENT NAME:	ACCOUNT NO.:

Have you recently or are you now experiencing numbness and/or tingling in your leg, foot, arm or hand?	❑ Yes	❑ No	❑ Right	❑ Left
If yes, in which body part?				
Have you recently or are you now experiencing weakness in your arms?	❑ Yes	❑ No	❑ Right	❑ Left
In your legs	❑ Yes	❑ No	❑ Right	❑ Left
Have your experienced any of the following changes in urination?	❑ Increased frequency	❑ Inability to hold urine	❑ Dribbing after voiding	❑ Cannot pass urine
Have your experienced any of the following changes in your bowels?	❑ Constipation	❑ Diarrhea	❑ Loss of control	
Have you noticed changes in sexual function?	❑ Yes	❑ No		
If yes, what?				
Do you have headaches?	❑ Yes	❑ No		
Have you recently been depressed because of your pain?	❑ Yes	❑ No	❑ Sometimes	
Does the pain wake you up at night?	❑ Yes	❑ No		
How many hours per night do you sleep?				
Is the pain in your back and neck constant or intermittent?	❑ Constant	❑ Intermittent		
Is the pain in your leg and arm constant or intermittent?	❑ Constant	❑ Intermittent		
Which word in each group best describes your pain	❑ Dull ❑ Sharp	❑ Superficial ❑ Deep	❑ Burning ❑ Throbbing ❑ Shooting	❑ Stabbing ❑ Aching
Does the pain keep you from participating in activities your enjoy?	❑ Yes	❑ No		
If your pain severe enough to consider surgery?	❑ Yes	❑ No	❑ Maybe	

Please mark the activities that make your <u>pain worse</u>

❑ Sitting	❑ Standing	❑ Leaning forward	❑ Walking
❑ Lying on your side	❑ Lying on your back	❑ Lying on your stomach	❑ Driving
❑ Coughing/Sneezing	❑ Lifting	❑ Getting out of bed	

Please mark the activities that make your <u>pain better</u>

❑ Sitting	❑ Standing	❑ Leaning forward	❑ Walking
❑ Lying on your side	❑ Lying on your back	❑ Lying on your stomach	❑ Driving
❑ Coughing/Sneezing	❑ Lifting	❑ Getting out of bed	

PATIENT NAME:	ACCOUNT NO.:

Please check the boxes next to those treatments you have used for your present condition. Then indicate whether the treatment was helpful or not helpful.

Treatment	Helpful	Not Helpful
❑ **Physical therapy** If so, how many visits?		
❑ **Hot packs/ice, massage, muscle stimulation, ultrasound, etc.**		
❑ **Exercises for proper posture** (stabilization)		
❑ **Exercises to build strength/endurance** (bike,treadmill, etc.)		
❑ **Back School education**		
❑ **Work hardening/conditioning**		
❑ **Traction**		
❑ **Chiropractic Adjustment**		
❑ **Acupuncture**		
❑ **Epidural Injection** If so, how many visits have you had?		
❑ **TENS Unit**		
❑ **Pain Medicine**		
❑ **Prednisone**		
❑ **Brace**		

Please mark the following tests you have undergone for your present condition.

Test	Date of Testing	Location of Testing (Hospital etc.)	Place a check for those results you will bring or have sent to THC
❑ **Regular spine x-ray**			
❑ **CT Scan**			
❑ **MRI**			
❑ **Myelogram**			
❑ **EMG (needle test)**			
❑ **Discogram**			
❑ **Bone Scan**			

Have you had back or neck problems before? If yes, describe below. ❑ Yes ❑ No

Description of Injury	Description of Injury	Months off Work

Have you ever had any previous injuries at work? If yes, describe below. ❑ Yes ❑ No

Description of Injury	Description of Injury	Months off Work

If you had previous episodes, did they cause any of the following?

❑ Back or neck pain only			
❑ Leg or arm pain only	❑ Right	❑ Left	❑ Both
❑ Back pain and leg pain	❑ Right	❑ Left	❑ Both
❑ Neck pain and arm pain	❑ Right	❑ Left	❑ Both

PATIENT NAME:	ACCOUNT NO.:

Have you had any previous surgeries on or relating to your **neck or back**? ❑ Yes ❑ No

Procedure	Date	Surgeon

What were your symptoms before your last surgery?

❑ Back pain only
❑ Back and right leg pain
❑ Back and left leg pain
❑ Back and pain in both legs
❑ Neck pain only
❑ Neck and right arm pain
❑ Neck and left arm pain
❑ Neck and pain in both arms

Did you improve after your last surgery?

How long were you better after your last surgery?

❑ Unknown
❑ 1 day
❑ 1 month
❑ 3 months
❑ 6 months
❑ 6-12 months
❑ 1 year
❑ 1-2 years
❑ 2-3 years
❑ 3-5 years
❑ more than 5 years

What was your work status after your last surgery?

❑ Returned to same job
❑ Returned to same job part-time or light duty
❑ Retrained and worked at new job
❑ Never returned to work

List below all the physicians, chiropractors and clinics you have consulted for your present condition.

Name	Address	Date 1st Visit	Date Last Visit

How many hours of your usual work day do you spend?

Sitting:	Standing:	Walking:	Driving:	Lifting: How heavy?

Which type of duty are your currently working:	❑ Light duty	❑ Heavy duty
Do you want a different job?	❑ Yes	❑ No
Do you plan to return to your job?	❑ Yes	❑ No

Past Medical History (Please check any of the following problems you have had in the past)

❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Cancer
❑ Heart Attack
❑ Seizure
❑ Loss of Consciousness
❑ Unexplained Weight Loss
❑ Night Sweats
❑ Blood Clots
❑ Tuberculosis
❑ Arthritis
❑ Hepatitis (Yellow Jaundice)
❑ Asthma
❑ Stomach Ulcers
❑ Dizziness
❑ Fainting
❑ Difficulty Swallowing
❑ Chance in Ability to Pass Urine
❑ Fever
❑ Difficulty in Bowel Movements
❑ Prostatic Problems
❑ Kidnes Infections
❑ Kidney Stones
❑ Swelling of Toe or Finger Joints
❑ Headaches
❑ Infections
❑ Depression
❑ Strokes
❑ Other

PATIENT NAME:	ACCOUNT NO.:

Please list **ALL PAST HOSPITALIZATIONS** and **ALL PREVIOUS SURGERY**. If none, circle: **NONE**

Past Illnesses or Surgeries	Date

Medications

Do you have any allergies to medications? If yes, which ones? ❑ Yes ❑ No

Which medications are you currently using for your back or neck:

Medication	# per day	Medication	# per day

Which medications did you previously use for your back or neck?

Medication	# per day	Medication	# per day

Which medications are your taking for other problems? *List all of your medications*

Medication	# per day	Medication	# per day

Social History

Are you? ❑ Single ❑ Married ❑ Divorced ❑ Widow/Widower

If married, what is the age, health and occupation of your spouse? Age: Health: Occupation:

How much schooling have you completed?

❑ Completed less than high school
❑ Graduated from high school
❑ Completed 1 to 3 years of college
❑ Graduated from a 2 year associate degree program or technical school
❑ Graduated from college (Bachelor's degree or equivalent)
❑ Completed post-graduate or professional degree

PATIENT NAME:	ACCOUNT NO.:

Children	Age: Living at home: Age: Living at home: Age: Living at home:

Habits				
Drug Use:	❑ Yes	❑ No	Type:	Amount/day:
Alcohol Use:	❑ Yes	❑ No	Type:	Amount/day:
Tobacco Use:	❑ Yes	❑ No	Type:	Packs/day:
Have you ever had problems with alcohol or drug abuse:			❑ Yes	❑ No

Family History

Father:	❑ Alive & well	❑ Died	Age:	Cause of Death:
Mother:	❑ Alive & well	❑ Died	Age:	Cause of Death:

Did you have a happy childhood?	❑ Yes	❑ No
Is there a history of difficulty with anesthesia? If yes, please describe _____	❑ Yes	❑ No
Is there a history of malignant hyperthermia?	❑ Yes	❑ No
Is there a bleeding tendency in your family or yourself?	❑ Yes	❑ No

Occupational History	
Name of Employer:	
Occupation:	How long?:
Date Last Worked:	Previous Employment:

Please mark your current symptoms below. If you have none, please circle: **NONE**

❑ Weight loss or gain	❑ Frequent or unusual headache	❑ Bleeding problems
❑ Fatigue	❑ Hearing loss	❑ Nausea
❑ Fever	❑ Mouth or dental infection	❑ Vomiting
❑ Chills	❑ Loss of vision	❑ Diarrhea-chronic
❑ Night sweats	❑ Shortness of breath	❑ Incontinence
❑ Rashes	❑ Difficulty breathing	❑ Frequency or urine
❑ Birthmarks	❑ Productive cough	❑ Urgency of urine
❑ Open wounds or sores	❑ Chest pain or pressure	❑ Retention or urine
❑ Drainage	❑ Irregular heart beat	❑ Paralysis
❑ Multiple joint pain	❑ Swelling or ankles	❑ Loss of sensation
❑ Multiple joint swelling	❑ Blood clots in legs or lungs	❑ Depression
❑ Multiple join stiffness	❑ Varicose veins	❑ Episodes of mania
❑ Generalized muscle weakness	❑ Deformity	❑ Inability to sleep

PATIENT SIGNATURE:	DATE:
History Reviewed By	
	Date:
	Date:
	Date:

PATIENT NAME:	ACCOUNT NO.:

Modified by Fort Wayne Orthopaedics from the North American Spine Society questionnaire.

Please tell us HOW PAIN HAS AFFECTED YOUR ABILITY TO PERFORM the following daily activities during the last four weeks.

Dressing (check one box) ❑ I can usually dress myself without pain ❑ I can dress myself without increasing pain ❑ I can dress myself but paint increased ❑ I can dress myself but have significant pain ❑ I can dress myself but with very severe pain ❑ I cannot dress myself	**Sleeping** (check one box) ❑ I sleep well ❑ Pain occasionally interrupts my sleep ❑ Pain interrupts my sleep half of the time ❑ Pain often interrupts my sleep ❑ Pain always interrupts my sleep ❑ I never sleep well
Lifting (check one box) ❑ I can lift heavy objects without pain ❑ I can lift heavy objects but it is paintful ❑ Pain prevents me from lifting heavy objects but I can manage if they are on a table ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects if they are on a table. ❑ I can only lift light objects ❑ I cannot lift anything	**Social and Recreational Life** (check one box) ❑ My social and recreational life is unchanged. ❑ My social and recreatonal life is unchanged but it increases pain ❑ My social and recreational life is unchanged but it severly increases pain. ❑ Pain has restricted my social and recreational life. ❑ Pain has severely restricted my social and recreational life. ❑ I have esentially no social and recreational life because of pain
Walking (check one box) ❑ Pain does not prevent me from walking. ❑ Pain prevents me from walking more than 1 hour. ❑ Pain prevents me from walking more than 30 minutes. ❑ Pain prevents me from walking more than 10 minutes. ❑ I can only walk a few steps at a time. ❑ I am unable to walk.	**Traveling** (check one box) ❑ I can travel anywhere. ❑ I can travel anywhere but it gives me pain. ❑ Pain is bad but I can manage to travel over 2 hours. ❑ Pain restricts me to trips of less than 1 hour. ❑ Pain restricts me to trips of less than 30 minutes. ❑ Pain prevents me from traveling.
Sitting (check one box) ❑ I can sit in any chair as long as I like. ❑ I can only sit in a special chair for as long as I like. ❑ Pain prevents me from sitting more than 1 hour. ❑ Pain prevents me from sitting for more than 30 minutes. ❑ Pain prevents me from sitting more than a few minutes. ❑ Pain prevents me from sitting at all.	**Sex Life** (check one box) ❑ My sex life is unchanged. ❑ My sex life in unchanged but causes some extra pain. ❑ My sex life is nearly unchanged but is very painful. ❑ My sex life is severely restricted by pain. ❑ My sex life is nearly absent because of pain. ❑ Pain prevents any sex life at all.
Standing (check one box) ❑ I can stand as long as I want. ❑ I can stand as long as I want but it gives me pain. ❑ Pain prevents me from standing for more than 1 hour. ❑ Pain prevents me from standing for more than 30 minutes. ❑ Pain prevents me from standing for more than 10 minutes. ❑ Pain prevents me from standing at all.	**Pain Intensity** (check one box) ❑ I can tolerate the pain I have without having to use pain killers. ❑ The pain is bad but I manage without taking pain killers. ❑ Pain killers give complete relief from pain. ❑ Pain killers give moderate relief from pain. ❑ Pain killers give very little relief from pain. ❑ Pain killers have no effect on the pain and I do not use them.

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PATIENT NAME:	ACCOUNT NO.:
TIMEPOINT:	DATE:

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every equestion by filling in the appropriate box. If you are unsure about how to answer the questions, please proviate the best answer you can.

1. Are you male or female? ❑ Male ❑ Female

2. How old were you on your last birthday: ❑ Less than 35 ❑ 35-44 ❑ 45-54 ❑ 55-64 ❑ 65-74 ❑ 75-84 ❑ 85 or older

3. In general, how would you say your health is? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

4. Comapred to one year ago, how would you rate your health in general now?

❑ Much better now ❑ Somewhat better now ❑ About the same ❑ Somewhat worse now ❑ Much worse now than 1 year ago.

5. The following items are about activities you might do during a typcial day. Does your helt limit you in these activities? If so, how much? (Mark one box at each line)

	Yes, limited a lot	Yes, limited A little	No, not limited at all
a) **Vigorous activities** such as running, lifting heavy objects, participating in strenuous sports			
b) **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling or playing golf			
c) Lifting or carrying groceries			
d) Climbing **several** flights of stairs			
e) Climbing **one** flight of stairs			
f) Bending, kneeling or stooping			
g) Walking **more than a mile**			
h) Walking **several blocks**			
i) Walking **one block**			
j) Bathing or dressing yourself			

6. During the past **4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of your **physical health**? (Mark one box on each line)

a) Cut down the **amount of time** you spent on work or other activities	❑ Yes	❑ No
b) **Accomplished less** than you would like	❑ Yes	❑ No
c) Were **limited in the kind** of work or other activities	❑ Yes	❑ No
d) Had **difficulty** performing the work or other activities (for example, it took extra effort)		

7. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as aresult of any amotional problems (such as feeling depressed or anxious)? (Mark one box on each line)

a) Cut down the **amount of time** you spent on work or other activities	❑ Yes	❑ No
b) **Accomplished less** than you would like	❑ Yes	❑ No
c) **Didn't do work** or other activities as carefully as susual	❑ Yes	❑ No

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PATIENT NAME:	ACCOUNT NO.:
TIMEPOINT:	DATE:

8. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups: (mark one box)

❑ Not at all ❑ Slightly ❑ Moderately ❑ Quite a bit ❑ Extremely

9. How much bodily pain have you had in the **past 4 weeks**? (mark one box)

❑ None ❑ Very Mild ❑ Mild ❑ Moderate ❑ Severe ❑ Very Severe

10. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (more one box)

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

11. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each questions, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks did you experience the following? (mark one box on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?						
b) Have you been a very nervous person?						
c) Have you felt so down in the dumps nothing could cheer you up?						
d) Have you felt calm and peaceful?						
e) Did you have a lot of energy?						
f) Have you felt downhearted and blue?						
g) Did you feel worn out?						
h) Have you been a happy person?						
i) Did you feel tired?						

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, realtives, etc.) (mark one box)

❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time ❑ None of the time

13. Please choose the answer that best describes how true or false each of the following statements is for you. (Mark one box on each line)

	Definitely true	Mostly true	Don't know	Mostly false	Defintely false
a) I seem to get sick a little easier than other people					
b) I am as healthy as anybody I know					
c) I expect my health to get worse					
d) My health is excellent					

14. Have you ever filled out this form before? ❑ Yes ❑ No ❑ Don't remember