VICTORIA
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Patient Questionnaire

How did you hear about us?

□ Internet □ Primary Care Physician □ Friend/Family □ Other_____

Patient's Legal Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Cardiologist: _____ Pain Management: _____

Reason for Visit: My area of pain and symptoms are: _____

_____

_____

Date of injury or when symptoms first began:_____

Do you have problems performing daily activities? If yes, please provide examples: _____

Please identify any habits or devices use to walk, move, or do daily chores: _____

Have you had physical therapy for this problem? □ No □Yes Did it help? □ No □Yes

Date of last session: _____

Do you exercise routinely? □ No □Yes If yes, how often?_____

Visit related to Worker's Comp? Y / N Date of Injury:_____

Visit related to Vehicle Accident? Y / N Date of Accident: _____

Please identify any names and dates of other physicians that have treated you for your spinal condition:

Physician	Date	Treatment

Have you ever had any injections to your spine? □ Yes □ No

Date (s) & type (s) of injection?	Number of injection (s)?	Did the injection help?

Preferred Pharmacy: _____ Phone: _____

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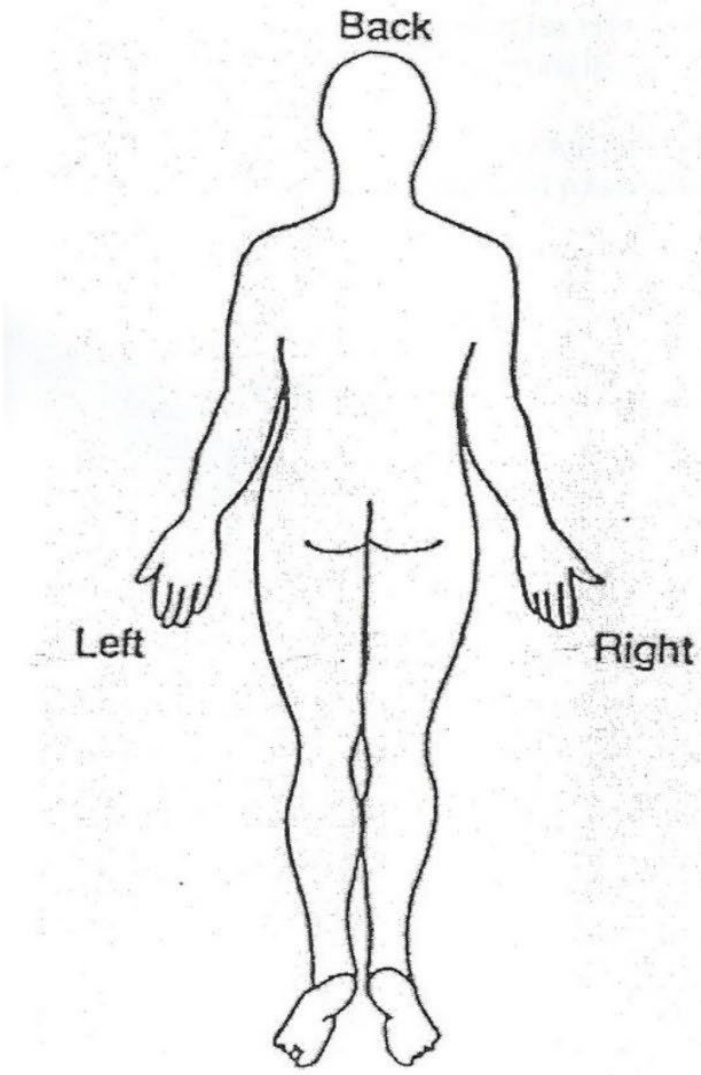
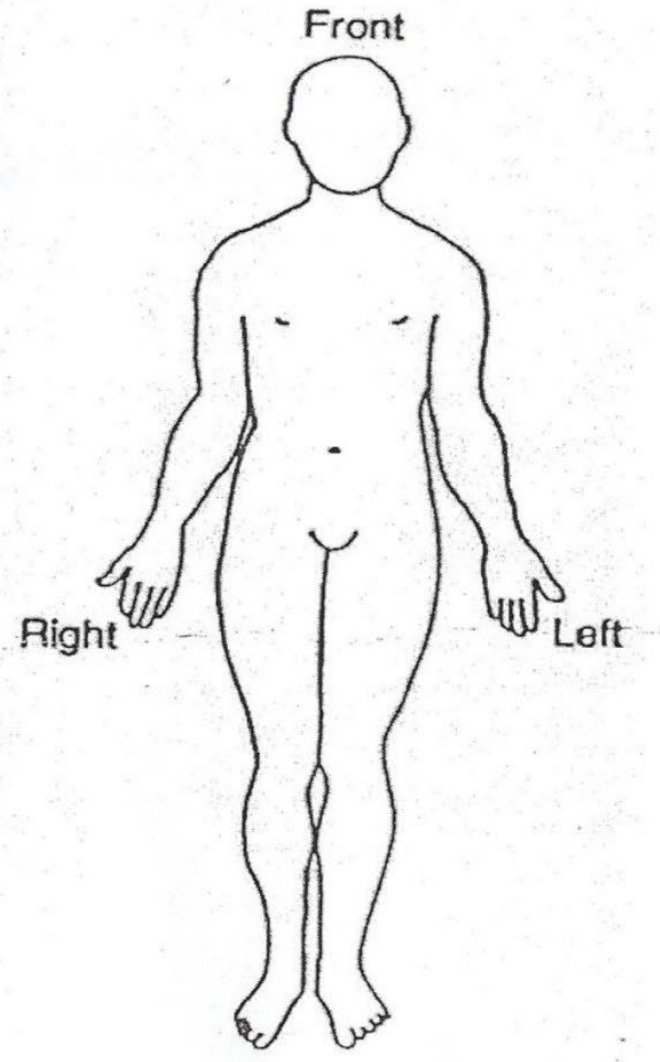
Patient Pain Diagram

INSTRUCTIONS: Check all that apply and rate each.

Pain Severity Scale: MILD 1 2 3 4 5 6 7 8 9 10 INTOLERABLE

□ NUMBNESS
□ DEEP ACHE OR PAIN
□ BURNING
□ STABBING
□ PINS & NEEDLES
□ Other: _____





What aggravates pain: _____

Has there been any changes in your bladder or bowel functions? □ No □ Yes If yes, what changes: _____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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This questionnaire has been designed to give the 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 ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

NECK DISABILITY INDEX (NDI)

This questionnaire is designed to give the health care provider information as to how your neck pain has affected your ability to manage in your every day life. In each section, mark only the ONE box that applies to you. We realize that you consider that two of the statements in any one section relates to you, but just mark the one that most closely describes your problem today.

1 - PAIN INTENSITY

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst pain imaginable at the moment

2 - PERSONAL CARE (E.G., WASHING, DRESSING, ETC.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself, but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed; I wash with difficulty and stay in bed

3 - LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights, but it gives me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (like on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light-to-medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4 - READING

- ☐ I can read as much as I want with no neck pain
- ☐ I can read as much as I want with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I cannot read at all

5 - HEADACHES

- ☐ I have no headaches at all
- ☐ I have slight headaches that come infrequently
- ☐ I have moderate headaches that come infrequently
- ☐ I have moderate headaches that come frequently
- ☐ I have severe headaches that come frequently
- ☐ I have headaches almost all of the time

6 - CONCENTRATION

- ☐ I can concentrate fully when I want with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty concentrating when I want to
- ☐ I have a lot of difficulty concentrating when I want to
- ☐ I have a great deal of difficulty concentrating when I want to
- ☐ I cannot concentrate at all

7 - WORK

- ☐ I can do as much work as I want
- ☐ I can only do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I cannot do any work at all

8 - DRIVING

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I can't drive my car as long as I want because of moderate neck pain
- ☐ I can hardly drive at all because of severe neck pain
- ☐ I can't drive my car at all

9 - SLEEPING

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed (1 to 2 hours sleepless)
- ☐ My sleep is moderately disturbed (2 to 3 hours sleepless)
- ☐ My sleep is greatly disturbed (3 to 5 hours sleepless)
- ☐ My sleep is completely disturbed (5 to 7 hours sleepless)

10 - RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain
- ☐ I am able to engage in all my recreation activities with some neck pain
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of neck pain
- ☐ I am able to engage in a few of my usual recreation activities because of neck pain
- ☐ I can hardly do any recreation activities because of neck pain
- ☐ I can't do any recreation activities at all because of neck pain

PAIN SCALE

Rate the severity of your pain by checking one box of the scale.

No Pain **Excruciating Pain**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Please list medications taken for your pain/discomfort.

MEDICATION	WHEN-HOW LONG DID YOU TAKE THE MEDICATION?	DID THE MEDICINE HELP?
ACETAMINOPHEN (Tylenol)		□ YES □ NO □ N/A
Acetaminophen with Codeine (Tylenol #3 or #4)		□ YES □ NO □ N/A
Oxycodone		□ YES □ NO □ N/A
Hydrocodone with Acetaminophen (Norco)		□ YES □ NO □ N/A
Tramadol		□ YES □ NO □ N/A
OTHER ANTI INFLAMMORIES:		
Aspirin		□ YES □ NO □ N/A
Naproxen (Aleve)		□ YES □ NO □ N/A
Ibuprofen (Motrin)		□ YES □ NO □ N/A
Celecoxib (Celebrex)		□ YES □ NO □ N/A
Meloxicam (Mobic)		□ YES □ NO □ N/A
Methylprednisolone (Medrol)		□ YES □ NO □ N/A
Hydrocortisone (solu-Cortef)		□ YES □ NO □ N/A
MUSCLE RELAXERS:		
Cyclobenzaprine (Flexeril)		□ YES □ NO □ N/A
Skelaxin		□ YES □ NO □ N/A
Soma		□ YES □ NO □ N/A

Medications:

Medications	Dosage	Time/day	Medication	Dosage	Time/Day

Drug Allergies:

Medication/food/Other Agent	Reaction or side of effect

Social History:

Tobacco: Y/N	Type: Yrs Smoked: Yr Quit:
Chewing Tobacco: Y/N	Comments:
Alcohol: Y/N	None Occasional Moderate Heavy
Illicit Drug Use: Y/N	Recreational: Y/N Ever use Needles? Y/N
Marital Status: Single Married Widowed Divorced	Comments:
Is blood transfusion acceptable in case of an emergency? Y/N	Comments:

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Past Medical History:

Anemia	Y/N	Comments:
Anxiety disorder	Y/N	
Arthritis	Y/N	
Asthma	Y/N	
Autoimmune disease	Y/N	
Bleeding disorder	Y/N	
Bronchitis	Y/N	
COPD	Y/N	
Cancer	Y/N	Type:
Chronic ear infection	Y/N	
Coronary Artery disease	Y/N	
Deep Vein Thrombosis	Y/N	
Depression	Y/N	
Diabetes	Y/N	
Difficulty Swallowing	Y/N	
Diverticulitis	Y/N	
Gout	Y/N	
Head Aches/Migraines	Y/N	
Heart disease	Y/N	
Hepatitis	Y/N	
High cholesterol	Y/N	
Hypertension	Y/N	
Kidney Disease	Y/N	
Kidney Stones	Y/N	
Liver Disease	Y/N	
Nasal Polyps	Y/N	
Osteoporosis	Y/N	
Pulmonary Embolism	Y/N	
Seizures/Epilepsy	Y/N	
Stroke	Y/N	
Tuberculosis	Y/N	
Other:		

Past Surgical History:

Surgery		Date	Surgery		Date
Cervical Spine Surgeries	Y/N		Thoracic Spine Surgeries	Y/N	
Lumbar Spine Surgeries	Y/N		Cardiac Surgery	Y/N	
Other:					

Family History:

Arthritis:	□ Mother	□ Father
Osteoporosis:	□ Mother	□ Father
Cancer: Type	□ Mother	□ Father
Diabetes:	□ Mother	□ Father
Heart Disease:	□ Mother	□ Father
Hypertension:	□ Mother	□ Father
Other:	□ Mother	□ Father

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CONSENT/AUTHORIZATION for TREATMENT

1) I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab tests which may be ordered by my provider at San Antonio Spine Center.

2) I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent, I assign all rights, title and interest and authorize direct payment to the San Antonio Spine Center of any insurance benefits or benefits under the Social Security Act for the services. San Antonio Spine Center will assist in billing my insurance company, but I am financially responsible for charges not collected by this assignment. I authorize San Antonio Spine Center to bill my insurance or third-party payor and receive payment from them directly.

3) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, San Antonio Spine Center may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore, San Antonio Spine Center may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed:_____ Date: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____Date:_____

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Cancellation Policy/ No Show Policy

1. **Cancellation/No Show policy for Doctor Appointment**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance company.

2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled time we will have to reschedule/cancel the appointment.

Patient Signature	Patient Printed Name	Date

Acknowledgement of Notice of Privacy Practices

Was a notice of Privacy Practices given to the patient or their personal representation? Y/N

Signature	Date

Release of Billing Information & Assignment of Benefits

By signing this form, I hereby authorize payment directly to San Antonio Spine Center for any surgical and/or medical benefits. I also authorize San Antonio Spine Center to file all necessary papers to insurance and release any copies of medical records requested by my insurance company for determining benefits. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues.

Signature	Date

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Photo Consent Form

I, _____ , hereby grant permission to Dr. Kevin Richardson and/or San Antonio Spine Center to take and use: photographs and/or digital images of me for use on social media, websites, brochures, online listings and other marketing materials.

I authorize the use of these images without compensation to me. All prints, digital reproductions shall be the property of Dr. Kevin Richardson and/or San Antonio Spine Center.

Date _____

First Name _____

Last Name _____

Signature _____