

# Enid Pain and Spine

## New Patient form

**Patient name      DOB      Date      Preferred phone**

Patient name	DOB	Date	Preferred phone

Referring provider	Primary care provider	Main pain area
MICHAEL		

### 1. Pain summary

Pain started / duration: \_\_\_\_\_

Main pain area: \_\_\_\_\_

Related to injury / accident:  No  Yes  Work-related  Auto

Pain pattern:  Constant  Comes & goes

Pain quality (check all that apply)

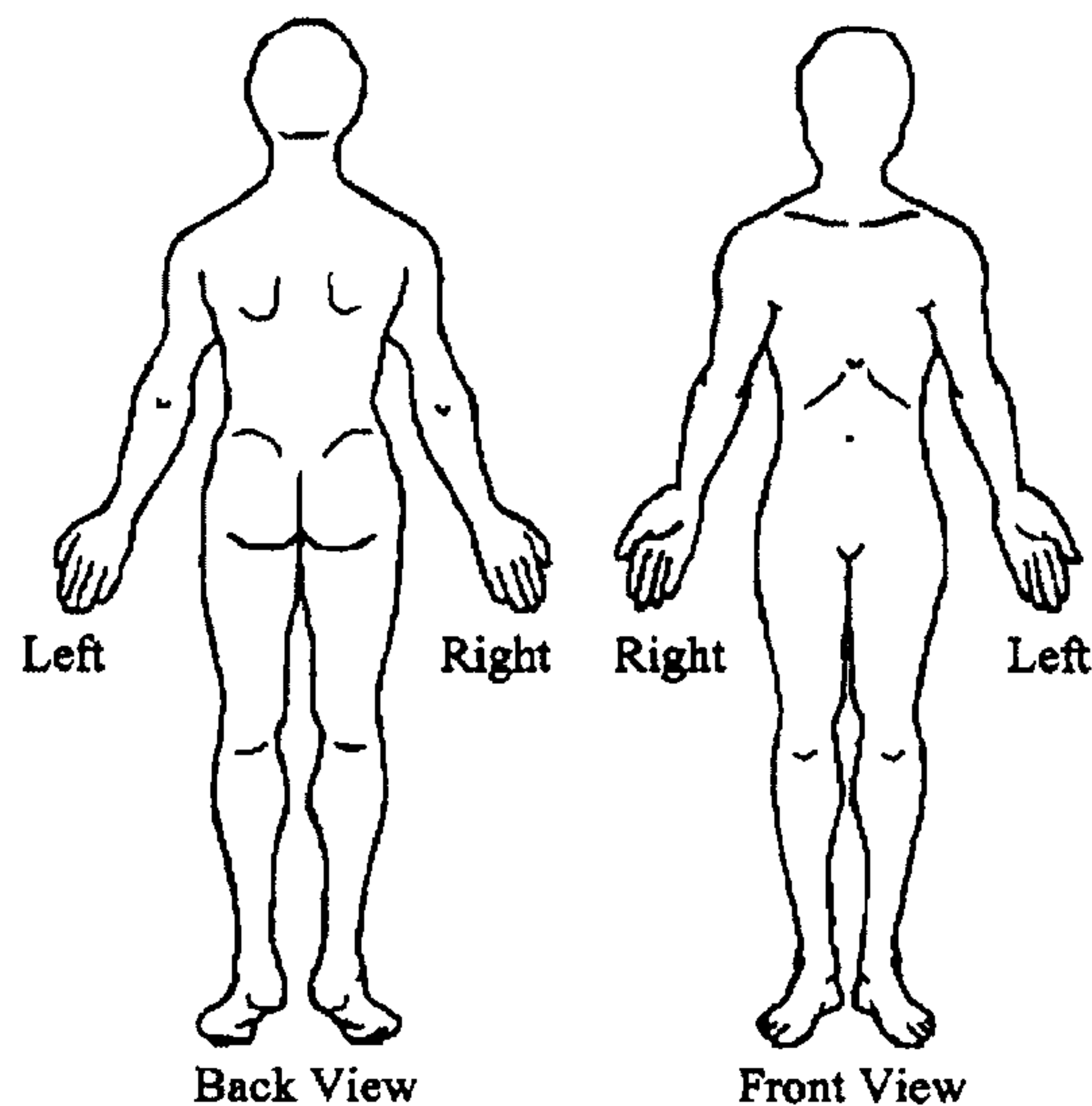
- |  |  |
|--|--|
| <input type="checkbox"/> Aching              | <input type="checkbox"/> Burning             |
| <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Stabbing / shooting |
| <input type="checkbox"/> Radiating           | <input type="checkbox"/> Throbbing           |
| <input type="checkbox"/> Cramping            | <input type="checkbox"/> Weakness            |

What makes it worse? \_\_\_\_\_

What helps? \_\_\_\_\_

### Pain location

Shade or circle where it hurts.



Draw arrows if pain travels or radiates.

### 2. Baseline pain / function score

Average pain (past week)	Worst pain (past week)	Function effect 0 = none 10 = unable
___/10	___/10	___/10

Activities limited by pain (check all that apply)

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Standing           |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Bending / lifting  |
| <input type="checkbox"/> Sleep    | <input type="checkbox"/> Work / chores      |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Dressing / bathing |
| <input type="checkbox"/> Driving  | <input type="checkbox"/> Stairs             |

Other affected activities: \_\_\_\_\_

## Enid Pain and Spine

### 3. Conservative care tried for this complaint

Treatment	Done?	Dates / duration	Helped? No / Some / Good
Physical therapy			
Home exercise / stretching			
Chiropractic / manual therapy			
Activity modification			
Heat / ice / TENS / brace			
Prescription or OTC pain medicine			

### 4. What are you doing now for ongoing relief?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Home exercise         | <input type="checkbox"/> Stretching       | <input type="checkbox"/> Walking                   |
| <input type="checkbox"/> Gym / exercise        | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Heat                      |
| <input type="checkbox"/> Ice                   | <input type="checkbox"/> TENS             | <input type="checkbox"/> Brace                     |
| <input type="checkbox"/> Massage               | <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Medications as prescribed |
| <input type="checkbox"/> Activity modification | <input type="checkbox"/> Counseling       | <input type="checkbox"/> Other                     |

How often: \_\_\_\_\_

What helps the most right now? \_\_\_\_\_

### 5. Prior relevant procedures and imaging

Prior pain procedures / surgery related to this complaint

Relevant imaging / tests/MRI /CT/XRAY

Date	Procedure / area	Relief %	How long?

Test	Area	Date	Where done

### 6. Current pain medications and safety

Medication	Dose	Does it help? No / Some / Yes

Medication side effects:  None  Nausea  Constipation  Dizziness  Sedation  Other

Safety / planning:  Blood thinner  Diabetes  Contrast allergy  Recent falls

# ENID PAIN & SPINE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Follow Up

Review of Systems Please mark any systems you have experienced in the **last month**  
If not marked it is considered negative or non-pertinent.

<p><b>Constitutional</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Appetite, excessive</li> <li><input type="checkbox"/> Appetite, poor</li> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Fevers</li> <li><input type="checkbox"/> Insomnia</li> </ul> <p><b>Head</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Grinding Teeth</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Jaw Pain or Click</li> <li><input type="checkbox"/> Tooth Pain</li> </ul> <p><b>Eyes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred Vision</li> <li><input type="checkbox"/> Floaters or Spots</li> <li><input type="checkbox"/> Vision Change</li> <li><input type="checkbox"/> Vision Loss</li> </ul> <p><b>ENT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ear Pain</li> <li><input type="checkbox"/> Hearing Loss</li> <li><input type="checkbox"/> Ringing or Buzzing</li> <li><input type="checkbox"/> Nosebleed</li> <li><input type="checkbox"/> Sinus Pain</li> <li><input type="checkbox"/> Sinus Congestion</li> <li><input type="checkbox"/> Sinus Infection</li> <li><input type="checkbox"/> Change in Taste</li> <li><input type="checkbox"/> Dry Mouth</li> <li><input type="checkbox"/> Sore Throat</li> <li><input type="checkbox"/> Trouble Swallowing</li> </ul>	<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood Clots</li> <li><input type="checkbox"/> Chest Pain                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Short of Breath with Activities</li> </ul> </li> <li><input type="checkbox"/> Irregular Heartbeat</li> <li><input type="checkbox"/> Lightheaded</li> <li><input type="checkbox"/> Swelling Feet</li> </ul> <p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Frequent Colds</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Short of Breath</li> <li><input type="checkbox"/> Wheezing</li> </ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Heartburn/Reflux</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Ulcer</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Bloody or Dark Stools</li> <li><input type="checkbox"/> Loss of Bowel Control</li> </ul>	<p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Broken Bones</li> <li><input type="checkbox"/> Difficulty Standing</li> <li><input type="checkbox"/> Difficulty Sitting</li> <li><input type="checkbox"/> Difficulty Walking</li> <li><input type="checkbox"/> Joint Stiffness</li> <li><input type="checkbox"/> Joint Swelling</li> <li><input type="checkbox"/> Morning Stiffness</li> <li><input type="checkbox"/> Muscle Cramps</li> <li><input type="checkbox"/> Muscle Weakness</li> <li><input type="checkbox"/> Numb Hands/Fingers</li> <li><input type="checkbox"/> Numb Feet/Toes</li> </ul> <p><b>Neuro/Psych</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Difficulty Falling Asleep</li> <li><input type="checkbox"/> Difficulty Staying Asleep</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Head Injury</li> <li><input type="checkbox"/> Loss of Consciousness</li> <li><input type="checkbox"/> Loss of Sensation</li> <li><input type="checkbox"/> Poor Balance</li> <li><input type="checkbox"/> Poor Coordination</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Tingling Sensation</li> <li><input type="checkbox"/> Tremor or Shakes</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dry</li> <li><input type="checkbox"/> Itchy</li> <li><input type="checkbox"/> Rashes</li> </ul>	<p><b>Genitourinary</b></p> <p>-Urination that is:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bloody</li> <li><input type="checkbox"/> Burning</li> <li><input type="checkbox"/> Frequent</li> <li><input type="checkbox"/> Painful</li> <li><input type="checkbox"/> Kidney Stones</li> <li><input type="checkbox"/> Loss of Urinary Control</li> <li><input type="checkbox"/> Wake Up to Urinate</li> </ul> <p><b>Reproductive</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Infertility</li> <li><input type="checkbox"/> Pain with Sex</li> <li><input type="checkbox"/> Erection Problems</li> <li><input type="checkbox"/> Pelvic Pain</li> <li><input type="checkbox"/> Painful Periods</li> <li><input type="checkbox"/> Hot Flashes</li> <li>___ # of Pregnancies</li> <li>___ # of Live Births</li> <li>___ Age Periods Began</li> <li>___ Age Menopause Began</li> </ul> <p><b>Immune/Endocrine</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Easy Bruising</li> <li><input type="checkbox"/> Frequent Infections</li> <li><input type="checkbox"/> High / Low Blood Sugar</li> <li><input type="checkbox"/> Low thyroid</li> <li><input type="checkbox"/> High thyroid</li> <li><input type="checkbox"/> Hot Flashes</li> <li><input type="checkbox"/> Swollen Lymph Nodes</li> <li><input type="checkbox"/> Weight Gain or Loss</li> </ul>
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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

## NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

### SECTION 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 imaginable at the moment.

### SECTION 2 - PERSONAL CARE

- 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 causing 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 items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### SECTION 4 - 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 can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 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 the time.

### SECTION 6 - CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

### SECTION 7 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

### SECTION 8 - DRIVING

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive 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 because of neck pain.

### SECTION 9 - 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 can't read at all.

### SECTION 10 - RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

SCORE \_\_\_\_\_ [50]

BENCHMARK -5 = \_\_\_\_\_

# Modified Oswestry Low Back Pain Disability Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Read:**

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the one box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

<p><b>Section 1 - Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can tolerate the pain I have without having to use pain medication.</li> <li><input type="checkbox"/> The pain is bad but I manage without having to take pain medication.</li> <li><input type="checkbox"/> Pain medication provides me complete relief from pain.</li> <li><input type="checkbox"/> Pain medication provides me moderate relief from pain.</li> <li><input type="checkbox"/> Pain medication provides me little relief from pain.</li> <li><input type="checkbox"/> Pain medication has no effect on the pain</li> </ul>	<p><b>Section 6 - Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without increased pain.</li> <li><input type="checkbox"/> I can stand as long as I want but increases my pain.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than ½ hour.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 mins.</li> <li><input type="checkbox"/> Pain prevents me from standing at all.</li> </ul>
<p><b>Section 2 - Personal Care (Washing, Dressing, etc.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can take care of myself normally without causing increased pain.</li> <li><input type="checkbox"/> I can take care of myself normally but it increases my pain.</li> <li><input type="checkbox"/> It is painful to take care of myself and I am slow and careful.</li> <li><input type="checkbox"/> I need help but I am able to manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of my care.</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</li> </ul>	<p><b>Section 7 - Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from sleeping well.</li> <li><input type="checkbox"/> I can sleep well only by using pain medication.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 6 hours.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 4 hours.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 2 hours.</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all</li> </ul>
<p><b>Section 3 - Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without increased pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it causes increased pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift only very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul>	<p><b>Section 8 - Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and does not increase my pain.</li> <li><input type="checkbox"/> My social life is normal, but it increases my level of pain.</li> <li><input type="checkbox"/> Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.</li> <li><input type="checkbox"/> Pain prevents me from going out very often.</li> <li><input type="checkbox"/> Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> I have hardly any social life because of my pain.</li> </ul>
<p><b>Section 4 - Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me walking any distance.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1 mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than ¾ mile</li> <li><input type="checkbox"/> Pain prevents me walking more than ½ mile</li> <li><input type="checkbox"/> I can only walk using crutches or a cane.</li> <li><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</li> </ul>	<p><b>Section 9 - Traveling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without increased pain.</li> <li><input type="checkbox"/> I can travel anywhere but it increases my pain.</li> <li><input type="checkbox"/> Pain restricts travel over 2 hours.</li> <li><input type="checkbox"/> Pain restricts travel over 1 hour.</li> <li><input type="checkbox"/> Pain restricts my travel to short necessary journeys under ½ hour.</li> <li><input type="checkbox"/> Pain prevents all travel except for visits to the doctor/therapist or hospital.</li> </ul>
<p><b>Section 5 - Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like.</li> <li><input type="checkbox"/> I can only sit in my favorite chair as long as I like.</li> <li><input type="checkbox"/> Pain prevents me sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than ½ hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 10 mins.</li> <li><input type="checkbox"/> Pain prevents me from sitting at all.</li> </ul>	<p><b>Section 10 - Employment/Homemaking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My normal homemaking/job activities do not cause pain.</li> <li><input type="checkbox"/> My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.</li> <li><input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).</li> <li><input type="checkbox"/> Pain prevents me from doing anything but light duties.</li> <li><input type="checkbox"/> Pain prevents me from doing even light duties.</li> <li><input type="checkbox"/> Pain prevents me from performing any job/homemaking chores.</li> </ul>