

Office Use Only
 Patient Account# _____
 Doctor # _____

Trinity Spine Center

Spine Questionnaire (Continued)



Please Complete ALL 4 Pages of the forms in blue/black ink

Name _____ SS# _____ Date _____

Last First M.I

Home # _____ Work # _____ Cell/Other# _____

Emergency contact name _____ Phone# _____

Who recommended us? _____ Address _____

Primary care doctor _____ Address _____

Employer _____ Address _____

Your Age _____ Male Female Are You Right Handed Left Handed

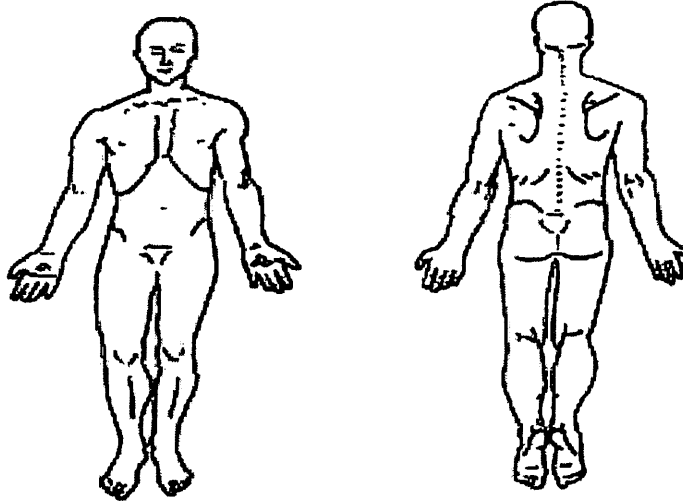
Is this a second opinion for treatment? Yes No

What is the main problem (s) for which you are seeking treatment at the Spine Center

Height: _____ Ft. _____ inch. Weight _____ lbs

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness =====	Pins & Needles 00000	Burning XXXXXX	Stabbing (Sharp) Pain /////	Aching *****
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Please circle on the line below how bad your pain is NOW.

Back Pain 0	—1—	—2—	—3—	—4—	—5—	—6—	—7—	—8—	—9—	—10 Worst
Leg Pain 0	—1—	—2—	—3—	—4—	—5—	—6—	—7—	—8—	—9—	—10 Worst
Neck Pain 0	—1—	—2—	—3—	—4—	—5—	—6—	—7—	—8—	—9—	—10 Worst
Arm Pain 0	—1—	—2—	—3—	—4—	—5—	—6—	—7—	—8—	—9—	—10 Worst

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I attest that all the information is accurate.

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Spine Questionnaire (Continued)



1. When did your present problem start? _____
2. Have you had similar pain in the past? No Yes, If Yes, when _____
3. How did your pain start? (Check all below that apply to you)
 Suddenly Lifting Bending Twisting Pulling
 Gradually After a fall No apparent cause Accident on _____
4. What activities make your pain worse? (Check all below that apply to you)
 Lying Sitting Exercise (During) Bending Forward Twisting
 Standing Walking Exercise (After) Bending Backward Coughing
5. What reduces your pain (Check all below that apply to you)
 Lying Sitting Exercise (During) Bending Forward Twisting
 Standing Walking Exercise (After) Bending Backward Coughing
6. What medications (including dosages) are you taking for your pain? NONE

Please include all prescription & non-prescription (over the counter) medicine, continue on reverse side

7. What conservative treatments have you tried for this current pain? (Check all below that apply)
 Physical Therapy, Who? _____ Home exercises Acupuncture Decompression
 Chiropractic, Who? _____ Protective Bracing Pain Management,
Who? _____
 Laser Spine Surgery (LSI in Tampa or Dr. Bonati), When? _____
8. Have you been seen for this current pain by: I have not been evaluated or treated
 Primary M.D./ PA/ NP _____ Emergency Room (Date) _____
 Urgent Care (Date) _____ Hospitalized (Date) _____
9. Have you had any of the following tests? No test performed
 X-rays (Date) _____ MRI (Date) _____ CT Scan (Date) _____
 EMG/NCS (Date) _____ Other _____
10. Have you had surgery for this pain or similar pain? No Yes
If Yes, Please list below the type of surgery you had, when and where performed, and the name of the surgeon:

-
11. Is your pain due to a work related injury? No Yes If Yes, when? _____
 12. Are you still working? No Yes If No, last Date on job: _____
 13. Is your pain due to an auto accident? No Yes If Yes, when? _____
 14. Is a lawyer involved in your injury? No Yes _____
If Yes, please provide us with your lawyer's name, address, & telephone number _____

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Trinity Spine Center Spine Questionnaire (Continued)



15. Review of Symptoms: (Please check all items below that apply to you)

- | | | |
|---|---|--|
| <input type="checkbox"/> UNEXPLAINED Weight loss/gain | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Bladder Accidents/Incontinence | <input type="checkbox"/> Arm Numbness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Bowel Accidents/Incontinence | <input type="checkbox"/> Leg Numbness | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> New Swelling (Legs or Arms) | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Change in Handwriting | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Genital Numbness | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Severe Nighttime pain | <input type="checkbox"/> New Balance Problems | <input type="checkbox"/> Bruising/Bleeding |
| <input type="checkbox"/> Recent Infections | <input type="checkbox"/> Difficulty buttoning buttons | <input type="checkbox"/> Visual Difficulties |
| <input type="checkbox"/> Other _____ | | |

16. Past Medical History: (Please check all items below that apply to you)

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer (please specify) _____ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Other (please specify) _____ | | | | |

17. Past Surgical History: (Please check all items below that apply to you)

- | | | | | | | | |
|--|--------------------------------|---------------------------------|--------------------------------------|-----------------------------------|---|---------------------------------|-------------------------------|
| <input type="checkbox"/> Lumbar (Lower Back) | <input type="checkbox"/> Heart | <input type="checkbox"/> Stents | <input type="checkbox"/> Lung | <input type="checkbox"/> Kidney | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Breast | <input type="checkbox"/> None |
| <input type="checkbox"/> Cervical (Neck) | <input type="checkbox"/> Bowel | <input type="checkbox"/> Hernia | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Prostate | <input type="checkbox"/> Arm/Leg, What? _____ | | |
| <input type="checkbox"/> Other (Please Describe) _____ | | | | | | | |

18. Allergies: Please check ALL medications that apply to you and the reaction/s you have:

- | | | |
|--|---|---|
| <input type="checkbox"/> Penicillin (Reaction) _____ | <input type="checkbox"/> Sulfa (Reaction) _____ | <input type="checkbox"/> Codeine (Reaction) _____ |
| <input type="checkbox"/> Iodine (Reaction) _____ | <input type="checkbox"/> Other _____ | |

19. Medications: Please list ALL medications that you are taking as well as dosages and how often.

Are you taking any blood thinners? No Yes If Yes, check all that apply and list dosages:
 Aspirin _____ Plavix _____ Coumadin _____ Other _____

20. Family History: (Please check any diseases diagnosed in your blood relatives)

- | | | | | | | | | |
|---------------------------------|---|---------------------------------|-----------------------------------|----------------------------------|------------------------------------|---|--------------------------------------|-------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiac | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back/Neck Pain | <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |
|---------------------------------|---|---------------------------------|-----------------------------------|----------------------------------|------------------------------------|---|--------------------------------------|-------------------------------|

21. Social History: (Please check all questions)

- Are you: Single Married Divorced Widowed Separated
Do you live: Alone With others: _____ Retirement Home? _____
Occupation: Retired Social Security Disability Employed Current Occupation _____
Is your job: Sedentary Light Medium Heavy
Have you ever smoked? No Yes Quit Packs per day, Number of years? _____
Do you currently drink alcohol? No Yes What? _____ How much per week? _____
Do you currently use illicit drugs? No Yes What? _____ How often? _____
Highest level of education? High School College Graduate Other _____

Patient Signature: _____ Date _____

I attest that all the information is accurate.

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Trinity Spine Center

Spine Questionnaire (Continued)



Please Read: This questionnaire has been designed to give the doctor information on how your pain has affected your ability to manage everyday life. PLEASE ANSWER EVERY SECTION AND MARK IN EACH SECTION ONLY ONE ANSWER that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes you

Section #1: PAIN INTENSITY

- I can tolerate the pain I have without pain killers
- The pain is bad but I manage without pain killers
- Pain killers give me complete relief of pain
- Pain killers give me moderate relief of pain
- Pain killers give me very little relief of pain
- Pain killers have no effect on pain and I do not use them.

Section #2: PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally without extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself but I am slow & careful
- I need some help but manage most of my personal care
- I need some help everyday in most aspects of self care sleep
- I do not get dressed, wash with difficult & stay in bed

Section #3: LIFTING

- I can lift heavy weights without causing pain
- I can lift heavy weights but it give extra pain
- Pain prevents me from lifting heavy weights off of the floor but I manage if they are conveniently positioned
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are convenient.
- I can lift only 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 1 Mile
- Pain prevents me from walking more than ½ Mile
- Pain prevents me from walking more than ¼ Mile
- I can only walk using a stick/cane or crutches
- I am in bed most of the time and have to crawl to the Toilet

Section #5: SITTING

- I can still sit in a 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 an hour
- Pain prevents me from sitting more than a ½ hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section # 6: STANDING

- I can stand as long as I want without extra pain
- I can stand as long as I want But it give me extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than a ½ hour
- 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
- Even when I take tablets, I have less than 2 hours
- Pain prevents me from sleeping at all.

Section #8: EMPLOYMENT / HOMEMAKING

- Job/homemaking causes no extra pain
- Job/homemaking increases pain, but I can still perform
- Can perform most duties, pain prevents heavier activity
- Pain prevents me from doing anything but light duties
- Pain prevents me from doing even light duties
- Pain prevents me from doing ANY job/homemaking

Section #9: SOCIAL LIFE

- My social life is normal and causes no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my life apart from limiting my more energetic interests (dancing , etc)
- Pain restricted my social life and I do not go out as often
- Pain has restricted my social life to home
- I have no social life because of pain

Section # 10: TRAVELING

- I can travel anywhere without pain
- I can travel anywhere but give extra pain
- Pain is bad but I can manage to journey over 2 hours
- Pain restricts me to journeys over 1 hour
- Pain restricts me to short necessary journeys less than 30 min.
- Pain prevents me from traveling except to the doctor or hospital

TOTAL (Office use): _____

Patient Signature: _____ Date _____

I attest that all the information is accurate.

Spine and Orthopaedic Specialists, PLLC
Trinity Spine Center
2040 Short Avenue, Suite 100
Odessa, FL, 33556

The Neck Disability Index

Patient name: _____ File# _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 (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 off the floor, 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-READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, with moderate pain in my neck.
- I can't read as much as I want, because of moderate pain in my neck.
- I can hardly read at all, because of severe pain in my neck.
- I cannot read 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 when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7-WORK

- I can do as much work as I want to.
- I can 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 can't do any work at all.

SECTION 8-DRIVING

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

SECTION 9-SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

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

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.