Neurological Surgery and Spine Surgery, S.C.

Medical History Form

Date: **Age:**
Name: **Gender**:M/F
Referring Doctor: **Height:**
Weight:

Right Handed/Left Handed:

Please describe your symptoms:

Are your symptoms (circle one): constant, periodic

Have you had similar symptoms previously?

What makes the pain worse?

What makes the pain better?

Which position makes the pain worst (circle one): Sitting, standing, lying down

Which position makes the pain better (circle one): Sitting, standing, lying down

Past Medical History
1.
2.
3.

Past surgical History
1.
2.
3.

Allergies:

Medications:

Social History (circle all applies)

Smoking: none or ….packs x ….years
Alcohol: none, social, daily
Living with: spouse, parents, kids

Family History (live, dead, include medical problems)
1. Father:
2. Mother:
3. Sibling:
4. Sibling:

Review of system (circle all that applies):

General: fever, chills, weight loss, weight gain
Muscle/Joints: pain, weakness, decreased ROM
Neurological: Weakness, numbness, tingling
Urologic: urinary incontinence, difficulty voiding
Psychiatric: depression, anxiety
Others:……

Work (circle one): Retired, Disabled, Working(fill the rest)

Place of employment:

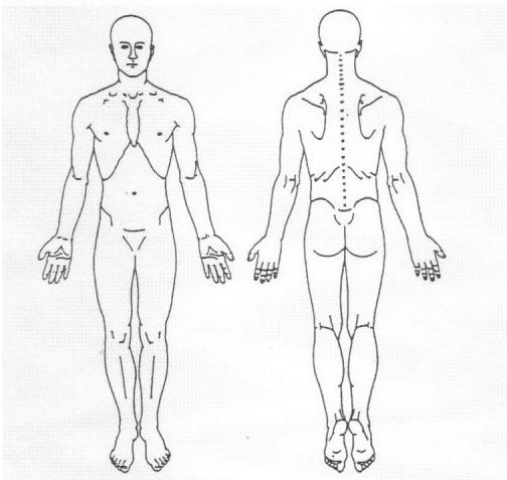
Job Description:

Circle which applies:
Heavy duty (50-100 lbs)
Medium duty (20-50 lbs)
Light duty (up to 20 lbs)
Desk work (less than 10 lbs)

Prior Treatments (circle all applies)

-Bed Rest (No relief, some relief, good relief)
-Physical therapy (No relief, some relief, good relief)
-Chiropractic (No relief, some relief, good relief)
-Cortisone injection (No relief, some relief, good relief)
-Brace (No relief, some relief, good relief)

Shade the affected area with pain



Pain Severity (circle one): 0 1 2 3 4 5 6 7 8 9 10

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.
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 read all statements in each section and then 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 worse than 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 objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can lift very light objects.
- ❑ 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 light 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 to 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 headache at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which 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.
- ❑ I can do only 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 work at all.
- ❑ I can't do any work at all.

SECTION 8 - DRIVING

- ❑ I can drive without any 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 hardly drive at all because of severe neck pain.
- ❑ I can't drive 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 (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

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

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

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 half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

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 present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I Extreme

Standard Form-36 Survey

Subjective Functional Outcomes Assessment

The S.F.- 36 Form is one of many outcomes assessments designed by the Medical Outcomes Trust in Boston, MA. It is designed to approximate the improvement in health status from a medical intervention.

INSTRUCTIONS: This survey asks for views about your health. This information will help keep track of how you feel and how well you are able to do your usual daily activities. Answer every question marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: (Circle one)

   Excellent 1
   Very good 2
   Good 3
   Fair 4
   Poor 5

2. Compared to one year ago, how would you rate your health in general at this time? (Circle one)

   Much better now than one year ago 1
   Somewhat better now than one year ago 2
   About the same as one year ago 3
   Somewhat worse than one year ago 4
   Much worse now than one year ago 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

ACTIVITIES	Yes, limited A lot	Yes, limited A little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

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

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities (for example - requiring an extra effort)	1	2

5. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(Circle one number on each line.)

	YES	NO
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. 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? (Circle one)

   Not at all 1
   Slightly 2
   Moderately 3
   Quite a bit 4
   Extremely 5

7. How much bodily pain have you had during the past 4 weeks? (circle one)

   None 1
   Very mild 2
   Mild 3
   Moderate 4
   Severe 5
   Very severe 6

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

   Not at all 1
   Slightly 2
   Moderately 3
   Quite a bit 4
   Extremely 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, 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: (circle one number 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?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm & peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

(Circle one)

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time 5

11. How TRUE or FALSE is each of the following statements to you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

The Standard Form 36 should be filled out by patients/clients and is a subjective measurement of how they are responding to a particular treatment (in our case, exercise and wellness). Be familiar with this form and be ready to answer questions that may arise from its completion.