Mercy

Mercy Spine Center
History

The information requested is important to your health.
Please answer all questions fully and accurately.

Patient Label

Patient Name:_____ Date of Birth_____
Physician who referred you to us:_____ PCP(if different)_____
REASON FOR VISIT: My area of pain or complaint(s): _____

1. What part of your body is experiencing the **greatest** pain?_____

2. Please rate the pain from 0 (no pain) to 10 (unbearable pain) ____

For Office Use Only
Vital Signs: BP _____
Pulse _____
Temp _____
Resp _____
Height _____
Weight _____

3. PAIN:
- ☐ Sudden Onset: Since:_____
- ☐ Gradual Onset: Since:_____
- ☐ Onset Following Injury Since:_____

4. BACK PAIN:
- ☐ No prior back pain
- ☐ History of low back pain for _____ years

Pain Quality:
- ☐ Aching ☐ Sharp ☐ Burning ☐ Cramping ☐ Stabbing
- ☐ Midline ☐ Left Side ☐ Right Side ☐ Across Back to Shoulders

If you have back and leg pain, what percent is Back Pain ____% Leg Pain _____%

5. NECK PAIN:
- ☐ No prior neck pain
- ☐ History of neck pain for _____ years

Pain Quality:
- ☐ Aching ☐ Sharp ☐ Burning ☐ Cramping ☐ Stabbing
- ☐ Midline ☐ Left Side ☐ Right Side ☐ Across Back to Shoulders

If you have neck and arm pain, what percent is Neck Pain ____% Arm Pain _____%

6. VISUAL ANALOG SCALE: Mark on the scale below your level of pain discomfort at Best, Worst, and Average

	None	Unbearable
BEST	]_____[	
WORST	]_____[	
AVERAGE	]_____[	

7. My Pain is **Worse** when I am: (CHECK ONE) ☐ Sitting ☐ Standing ☐ Walking ☐ Bending Over
8. My Pain is **Better** when I am: (CHECK ONE) ☐ Sitting ☐ Standing ☐ Walking ☐ Bending Over
9. I have tried: ☐ Psychological Treatment ☐ Operation_____ ☐ Physical Therapy ☐ Pain Clinic ☐ Chiropractor ☐ Medications

PHYSICIAN SIGNATURE_____ **DATE**_____

10. Are you: ☐ Right Handed ☐ Left Handed

11. Have you experienced loss of bowel and/or bladder control? ☐ **YES** ☐ **NO**

12. PAST MEDICAL HISTORY (Conditions/problems you have had in the past)

☐ Anemia (low blood count)	☐ Gout	☐ Mental Illness	☐ Prostate Problems
☐ Arthritis	☐ Heart Attack	☐ Rheumatic Fever	☐ Gastric Reflux
☐ Asthma	☐ Heart Trouble	☐ Seizures (convulsions)	☐ Hiatal Hernia
☐ Cancer	☐ Hepatitis	☐ Stomach Ulcers	☐ Blood Clots
☐ Cirrhosis	☐ High Blood Pressure	☐ Sugar Diabetes	☐ Stroke
☐ Emphysema	☐ Kidney Infection	☐ Thyroid Trouble	☐ Alcohol/Drug Abuse
☐ Gallstones	☐ Kidney Stones	☐ Tuberculosis	☐ Glaucoma
☐ Liver Disease	☐ Yellow Jaundice	☐ X-Ray Exposure to Head or Neck (except chest x-ray)	

13. PAST SURGICAL HISTORY (Check appropriate box and list the year of surgery)

☐ Appendix	_____	☐ Hernia, Hiatal	_____
☐ Bypass	_____	☐ Hernia, Inguinal (groin)	_____
☐ Cataracts	_____	☐ Hysterectomy	_____
☐ Gallbladder	_____	☐ Stomach Ulcer	_____
☐ Hemorrhoid	_____	☐ Tonsils/Adenoids	_____

☐ Other_____

14. Spinal Surgery:

☐ Cervical Spine	Date_____	Type_____
☐ Thoracic Spine	Date_____	Type_____
☐ Lumbar Spine	Date_____	Type_____

15. MEDICATIONS: Complete list below or present list of all medications including herbs, vitamins, aspirin, etc.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

16. MEDICATION ALLERGIES:_____
OTHER ALLERGIES:_____

17. FAMILY HISTORY Check the disease that runs in your family and family member affected using this code:

Mother (**M**) Father (**F**) Brother (**B**) Sister (**S**) Child (**C**) Grandparents (**GP**) Aunt (**A**) Uncle (**U**) Cousin (**CS**)

Example: Father and Brother with High Blood Pressure: (×) High Blood Pressure F, B

☐ Bleeding Trouble	_____	☐ Heart Attack	_____
☐ Cancer	_____	☐ High Blood Pressure	_____
☐ Colitis	_____	☐ Kidney Disease	_____
☐ Diabetes	_____	☐ Tuberculosis	_____
☐ Seizures (Epilepsy)	_____	☐ Ulcers	_____

☐ Other _____

Please be sure to complete page 3.

18. SOCIAL HISTORY

How often do you Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of Exercise? _____

Approximate number of alcoholic beverages consumed per week: _____

Do you chew tobacco? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

If you smoke, how many packs per day? _____

Total number of years smoking? _____

Education:

Circle highest level of schooling completed:

None 1 2 3 4 5 6 7 8 / 9 10 11 12 / 1 2 3 4

Elementary High School College

Occupation:

Briefly list job and approximate years employed:_____

If not working, when did you last work?_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partner

Number of Children: _____

Do you live alone? _____

Please be sure to complete page 4.

MERCY SPINE CENTER
CURRENT SYMPTOMS

Date of Injury/Accident:_____

Date of onset of symptoms if no injury or accident:_____

SYMPTOMS/REVIEW OF SYSTEMS:
(Indicate PRESENT Problem—If you leave one blank it will be considered not present)

Constitutional:	□ Fevers	□ Sleep Disorder	□ Weight Loss	□ Night Pain
Musculoskeletal/Joint:	□ Muscular Disease	□ Arthritis	□ Joint Pains	
Neurological:	□ Headaches	□ Migraines	□ Seizure Disorder	□ Stroke
Endocrine:	□ Diabetes	□ Thyroid Disease		
Hematology:	□ Anemia	□ Blood Clots	□ Bleeding Problems	□ Phlebitis
Cancer:	□ Lung	□ Breast	□ Colon	□ Prostate
	□ Skin	□ Stomach	□ Kidney	□ Bone
Urinary:	□ Blood in Urine	□ Frequent Urination	□ Trouble Starting Urination	
	□ Painful Urination	□ Prostate Disease	□ Trouble Stopping Urination	
	□ Kidney Disease	□ Kidney Stones	□ Loss of Bladder Control	
Respiratory:	□ Asthma	□ Bronchitis	□ Emphysema	□ COPD
	□ Pneumonia	□ Tuberculosis		
Cardiovascular:	□ Chest Pain	□ Shortness of Breath	□ High Blood Pressure	
	□ Palpitations	□ Mitral Valve Prolapse	□ Angina	
Reproductive:	□ Infections	□ Venereal Disease	□ Herpes	□ Impotence
Gastrointestinal:	□ Stomach Ulcers	□ Pancreatitis	□ Gall Bladder Trouble	□ Colitis
	□ Blood in stool	□ Hiatal Hernia	□ Liver Disease	
	□ Jaundice	□ Constipation	□ Loss of Bowel Control	
Immunological:	□ HIV Positive	□ AIDS		
Psychiatric:	□ Depression	□ Psychogenic Disorder	□ Mental Retardation	□ Anxiety
	□ Dementia	□ Schizophrenia		
Women Only:	□ Endometriosis	□ Birth Control Pills		
	□ Are You Pregnant?	□ Yes, Due Date _____	□ No	

All of the responses above are complete and correct to the best of my knowledge.

Patient Signature_____

Please be sure to complete page 5.

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information about how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE BOX in each section for the statement which best applies to you. We realize you may feel two or more statements in any section apply but shade ONLY the box that most clearly 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 very severe at the moment
- □ The pain is the worst imaginable at the moment

Section 2: Personal Care (e.g. washing, dressing)
- □ 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 help every day in most aspects of self care
- □ I do not get dressed, 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 me extra pain
- □ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. 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 only lift very lights weights
- □ I cannot lift or carry anything

Section 4: Walking
- □ Pain does not prevent me from walking any distances
- □ Pain prevents me from walking more than 2 miles
- □ Pain prevents me from walking more than 1 mile
- □ Pain prevents me from walking more than ½ mile
- □ I can only walk using a stick or crutches
- □ I am in bed most of the time

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 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 gives me extra pain
- □ Pain prevents me from standing for 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
- □ My sleep is never disturbed by pain
- □ My sleep is occasionally disturbed by pain
- □ Because of pain I have less than 6 hours sleep
- □ Because of pain I have less than 4 hours sleep
- □ Because of pain I have less than 2 hours sleep
- □ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- □ My sex life is normal and causes no extra pain
- □ My sex life is normal but causes some extra pain
- □ My sex life is nearly normal 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

Section 9: 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. sport
- □ 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 10: Traveling
- □ I can travel anywhere without pain
- □ I can travel anywhere but it gives me extra pain
- □ Pain is bad but I manage journeys over two hours
- □ Pain restricts me to journeys of less than one hour
- □ Pain restricts me to short necessary journeys under 30 minutes
- □ Pain prevents me from traveling except to receive treatment

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Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. Spine, 25(22):2940-2953. Davidson M & Keating J (2001) A Comparison of five low back disability questionnaires: reliability and responsiveness. Physical Therapy 2002;82:8-24.

Mercy

MZD

Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1. I feel downhearted and sad				
2. Morning is when I feel best				
3. I have crying spells or feel like it				
4. I have trouble getting to sleep at night				
5. I feel that nobody cares				
6. I eat as much as I used to				
7. I still enjoy sex				
8. I notice I am losing weight				
9. I have trouble with constipation				
10. My heart beats faster than usual				
11. I get tired for no reason				
12. My mind is as clear as it used to be				
13. I tend to wake up too early				
14. I find it easy to do the things I used to				
15. I am restless and can't keep still				
16. I feel hopeful about the future				
17. I am more irritable than usual				
18. I find it easy to make a decision				
19. I feel quite guilty				
20. I feel that I am useful and needed				
21. My life is pretty full				
22. I feel that others would be better off if I were dead				
23. I am still able to enjoy the things I used to				

Mercy

Tampa Scale-11 (TSK-11)

Date:

This is a list of phrases which other patients have used to express how the view their condition. Please circle the number that best describes how you feel about each statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I'm afraid I might injure myself if I exercise.	1	2	3	4
2. If I were to try to overcome it, my pain would increase.	1	2	3	4
3. My body is telling me I have something dangerously wrong.	1	2	3	4
4. People aren't taking my medical condition serious enough.	1	2	3	4
5. My accident/problem has put my body at risk for the rest of my life	1	2	3	4
6. Pain always means I have injured my body.	1	2	3	4
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening	1	2	3	4
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
9. Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
10. I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
11. No one should have to exercise when he/she is in pain.	1	2	3	4

Source: Woby et al. (2005), Psychometric properties of the TSK-11: A shortened version of the Tampa Scale for Kinesiophobia. Pain, 117, 137-144.

Mercy

IEQ

When injuries happen, they can have profound effects on our lives. This scale was designed to assess how your injury has affected your life.

Listed below are twelve statements describing different thoughts and feelings that you may experience when you think about your injury. Using the following scale, please indicate how frequently you experience these thoughts and feelings when you think about your injury.

0 - never **1** - rarely **2** - sometimes **3** - often **4** - all the time

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1. _____ Most people don't understand how severe my condition is.
2. _____ My life will never be the same.
3. _____ I am suffering because of someone else's negligence.
4. _____ No one should have to live this way.
5. _____ I just want to have my life back.
6. _____ I feel that this has affected me in a permanent way.
7. _____ It all seems so unfair.
8. _____ I worry that my condition is not being taken seriously.
9. _____ Nothing will ever make up for all that I have gone through.
10. _____ I feel as if I have been robbed of something very precious.
11. _____ I am troubled by fears that I may never achieve my dreams.
12. _____ I can't believe this has happened to me.

_____ Total