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fort wayne ORTHOPEDICS

DR WINTERS' BACK FORM

It is very important that you fill out this form as completely as possible before you arrive for your appointment. **If your injury is not work-related, please disregard this page and complete the remainder of the form.**

PATIENT NAME	ACCOUNT NO.

DATE OF VISIT:

Dear Back or Neck Patient:

The questionnaire you have received from Fort Wayne Orthopaedics, LLC will allow your physician to give you the best available treatment for your spinal problem.

If your injury is work-related and has been reported to your employer's worker's compensation carrier, to better facilitate the transfer of information regarding your care, we need you to complete the form below. Please contact your employer to obtain this information prior to your visit.

NAME OF EMPLOYER
EMPLOYER'S ADDRESS
WORKER'S COMPENSATION CARRIER (INSURANCE)
INSURANCE CO. ADDRESS
CASE MANAGER

If you have any other questions, please ask the nurse at the time of your appointment.

Thank you,

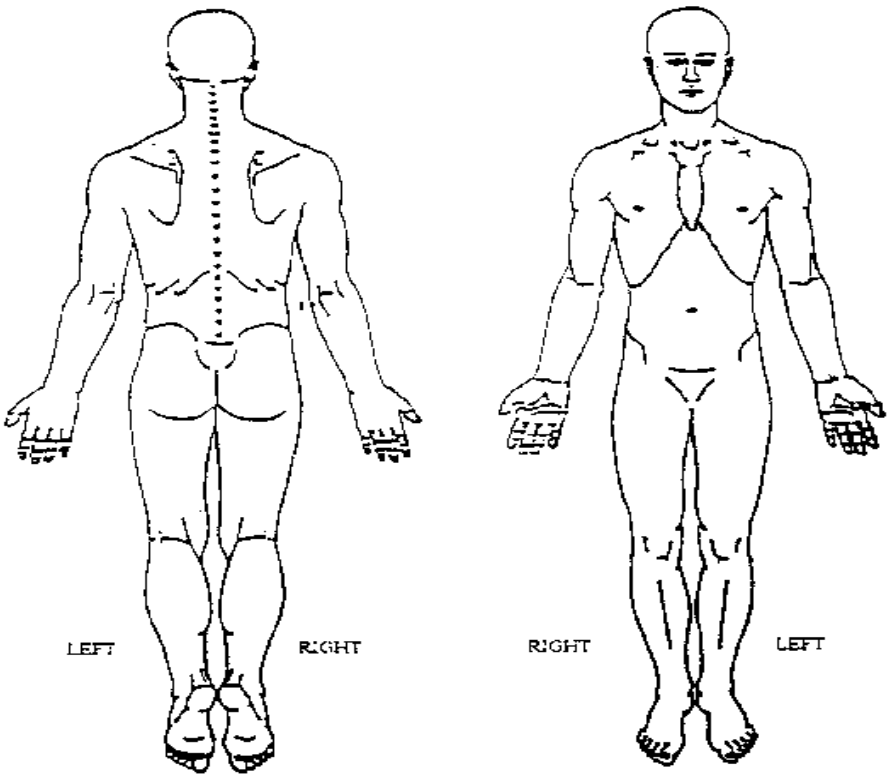
Fort Wayne Orthopaedics, LLC

Dr. _____

PATIENT NAME:	ACCOUNT NO.:
DATE OF VISIT:	TIMEPOINT:

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

Numbness	Burning	Ache	Pins & Needles	Stabbing
========	XXXXXX	^^^^^^^^	OOOOO	///////////



How would you describe your current pain ratio? (Please check one box)

Back Pain vs. Leg Pain			Neck Pain vs. Arm Pain		
✓	% Back Pain	% Leg Pain	✓	% Neck Pain	% Arm Pain
	100%	0%		100%	0%
	75%	25%		75%	25%
	50%	50%		50%	50%
	25%	75%		25%	75%
	0%	100%		0%	100%

HEIGHT:
WEIGHT:
RADIAL PULSE:

PAIN ASSESSMENT SCALE

Please circle the number from 0 to 10 that best describes your pain.

0 No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Worst Possible Pain

Describe your reason for your visit:_____

_____

When did the problem start? _____

_____

Was there an injury that caused the problem? If yes please describe.

_____

_____

Was the injury work related?_____

What symptoms are you currently experiencing?

_____

_____

_____

Mark the activities that make your pain worse:

☐ Sitting ☐ Walking ☐ Lying On Your Back ☐ Other_____

☐ Standing ☐ Leaning Forward ☐ Coughing / Sneezing ☐ Other_____

What activities or treatments make your pain better *(including medications)*: _____

_____

What activities or treatments have you tried that were NOT helpful *(including medications)*: _____

REVIEW OF SYSTEMS **(Please mark *current* symptoms)**

Constitutional ☐ **Normal**
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night sweats

Integumentary ☐ **Normal**
- ☐ Rashes
- ☐ Birthmarks
- ☐ Open wounds or sores
- ☐ Drainage

Musculoskeletal ☐ **Normal**
- ☐ Multiple joint pain
- ☐ Multiple joint swelling
- ☐ Multiple joint stiffness
- ☐ Generalized muscle weakness
- ☐ Deformity

ENTM ☐ **Normal**
- ☐ Frequency of unusual headache
- ☐ Hearing loss
- ☐ Mouth or dental infections

Eyes ☐ **Normal**
- ☐ Loss of vision

Respiratory ☐ **Normal**
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Productive cough

Cardiovascular ☐ **Normal**
- ☐ Chest pain or pressure
- ☐ Irregular heart beat
- ☐ Swelling of ankles
- ☐ Blood clots in legs or lungs
- ☐ Varicose veins

Hematologic ☐ **Normal**
- ☐ Bleeding Disorders

Gastrointestinal ☐ **Normal**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea-Chronic

Genitourinary ☐ **Normal**
- ☐ Incontinence
- ☐ Frequency of urine
- ☐ Urgency of urine
- ☐ Retention of urine

Neurological ☐ **Normal**
- ☐ Paralysis
- ☐ Loss of sensation

Psychiatric ☐ **Normal**
- ☐ Depression
- ☐ Episodes of mania
- ☐ Inability to sleep

Endocrine ☐ **Normal**
- ☐ Diabetes
- ☐ Thyroid Disorder

Right Handed ☐ Left Handed ☐ Ambidextrous ☐

MEDICAL HISTORY:

☐ Alcoholism	☐ Congestive Heart Failure	☐ Diabetes	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Alzheimer's	☐ COPD	☐ Drug Abuse	☐ Hypertension	☐ Scoliosis
☐ Anemia	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Heart Attack	☐ Seizures
☐ Arthritis	☐ Crohn's Disease	☐ Fibromyalgia	☐ Osteoporosis	☐ Sleep Apnea
☐ Asthma	☐ Blood Clots (DVT)	☐ Gout	☐ Parkinson's Disease	☐ Stroke
☐ Cancer	☐ Depression	☐ Headaches, migraine	☐ Kidney Disease	☐ Thyroid Disease

☐ Other_____ ☐ Other_____ ☐ Other_____

☐ Other_____ ☐ Other_____ ☐ Other_____

List **ALL** previous surgeries:

_____

_____

_____

_____

List any allergies to medicines: _____

_____

List all medicines that you are currently using: (Name, Dosage, and Frequency you take it)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY: (please circle if for M=mother, F=father, B=brother, S=sister)

☐Adopted/Unknown family history

☐Bleeding Disorder M F B S ☐Cancer (type)_____ M F B S ☐Diabetes M F B S

☐Heart Disease M F B S ☐Malignant Hyperthermia M F B S ☐Osteoporosis M F B S

☐Other_____ M F B S ☐Other_____ M F B S ☐Other_____ M F B S

SOCIAL HISTORY:

Tobacco Use: ☐ Current_____packs/perday ☐ Former ☐ Never

Alcohol Use: ☐ Yes ☐ No Amount _____

Caffeine Use: ☐ Yes ☐ No Amount cups per day_____ OR Amount ounces per day_____

This questionnaire has been designed to give us information as to 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 consider that two or more statements in any one section apply, but **please select only the one statement 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 is 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 some 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 lifting heavy weights off the floor, but I can manage if they are conveniently placed, e.g., on a table.
- ☐ Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything.

Section 4: Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than 2 kilometers.
- ☐ Pain prevents me from walking more than 1 kilometer.
- ☐ Pain prevents me from walking more than 500 meters.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

Section 5: Sitting
- ☐ I can sit in my 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.

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 for more than 30 minutes.
- ☐ Pain prevents me from standing for 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., sports.
- ☐ 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.

- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.