

NAME _____ DATE _____ DOB _____

My pain is (please circle)

Minimal Mild Moderate Severe Incapacitating

My overall condition is (please circle)

Improving Unchanging Getting Worse

I have been treated for this condition with: (please circle all that apply)

Physical Therapy Medications Chiropractic Epidural Injections
Other Injections Acupuncture

*Other _____

My pain is made worse with: (circle all that apply)

Standing Laying Walking Sneezing Bending Mornings
Sitting Coughing Lifting Driving My Pain is Constant

*Other _____

My pain is made better with: (circle all that apply)

Standing Sitting Laying Down Activity Rest
Shifting Positions Leaning Forward Nothing Relieves My Pain

*Other _____

I am: Single Married Divorced Widowed

I am: Employed Unemployed Retired

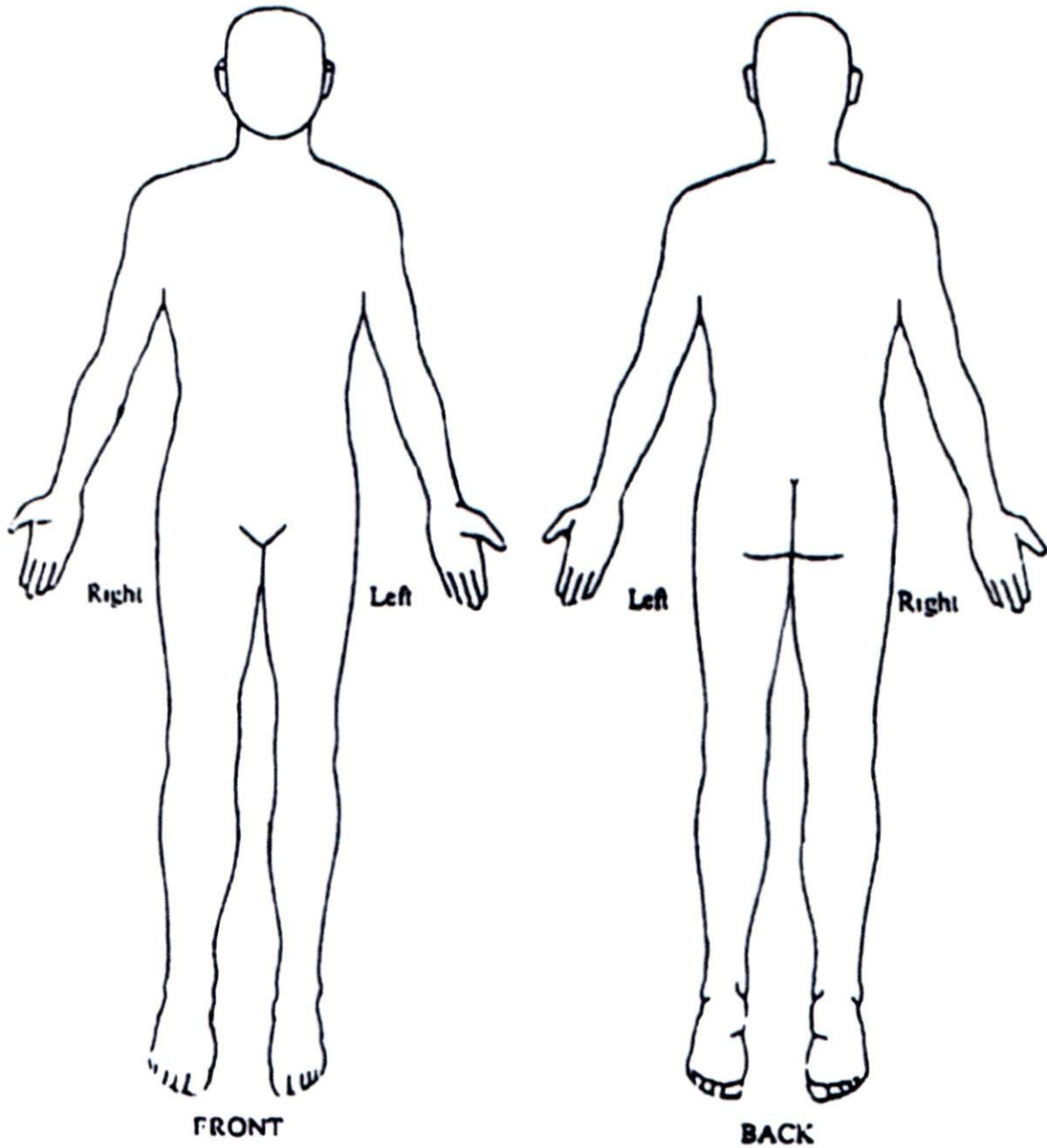
My Job Title Is: _____

My Employer Is: _____

I am presently working: Full Time Part Time Disabled from work since _____

Mark the areas on your body where you feel the described sensations. Use appropriate symbols and include all affected areas:

Ache ^^^^^ Numbness ooooo Pins & Needles ----- Burning xxxxx Stabbing ////



OSWESTRY NECK PAIN SCALE

Please rate the severity of your pain by marking a number below with an X:

No pain 0 1 2 3 4 5 Unbearable pain

First Name _____ Last Name _____ MRN _____ DOS _____ Physician _____ DOB _____

Instructions: Please mark through the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity

- 0 - I have no pain at the moment.
- 1 - The pain is very mild at the moment.
- 2 - The pain is moderate at the moment.
- 3 - The pain is fairly severe at the moment.
- 4 - The pain is very severe at the moment.
- 5 - The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- 0 - I can look after myself normally without causing extra pain.
- 1 - I can look after myself normally but it causes extra pain.
- 2 - It is painful to look after myself, and I am slow and careful.
- 3 - I need some help but can manage most of my personal care.
- 4 - I need help every day in most aspects of self-care.
- 5 - I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- 0 - I can lift heavy weights without extra pain.
- 1 - I can lift heavy weights, but it gives extra pain.
- 2 - Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, e.g., on a table.
- 3 - Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 4 - I can only lift very light weights at most.
- 5 - I cannot lift or carry anything.

Section 4 – Reading

- 0 - I can read as much as I want to with no pain in my neck.
- 1 - I can read as much as I want to with slight pain in my neck.
- 2 - I can read as much as I want to with moderate pain in my neck.
- 3 - I cannot read as much as I want to because of moderate pain in my neck.
- 4 - I can hardly read at all because of severe pain in my neck.
- 5 - I cannot read at all.

Please continue on page 2.

Instructions: Please mark through the **ONE NUMBER** in each section which most closely describes your problem. ☒

Section 5 – Headaches

- 0 - I have no headaches at all.
- 1 - I have slight headaches that come infrequently.
- 2 - I have moderate headaches that come infrequently.
- 3 - I have moderate headaches that come frequently.
- 4 - I have severe headaches that come frequently.
- 5 - I have headaches almost all the time.

Section 6 – Concentration

- 0 - I can concentrate fully when I want to with no difficulty.
- 1 - I can concentrate fully when I want to with slight difficulty.
- 2 - I have a fair degree of difficulty in concentrating when I want to.
- 3 - I have a lot of difficulty in concentrating when I want to.
- 4 - I have a great deal of difficulty in concentrating when I want to.
- 5 - I cannot concentrate at all.

Section 7 – Work

- 0 - I can do as much work as I want to.
- 1 - I can do my usual work, but no more.
- 2 - I can do most of my usual work, but no more.
- 3 - I cannot do my usual work.
- 4 - I can hardly do any work at all.
- 5 - I cannot do any work at all.

Section 8 – Driving

- 0 - I can drive my car without any neck pain.
- 1 - I can drive my car as long as I want with slight pain in my neck.
- 2 - I can drive my car as long as I want with moderate pain in my neck.
- 3 - I cannot drive my car as long as I want because of moderate pain in my neck.
- 4 - I can hardly drive my car at all because of severe pain in my neck.
- 5 - I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

- 0 - I am able to engage in all my recreation activities, with no pain in my neck.
- 1 - I am able to engage in all my recreation activities, with some pain in my neck.
- 2 - I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- 3 - I am able to engage in a few of my usual activities because of pain in my neck.
- 4 - I can hardly do any recreation activities because of pain in my neck.
- 5 - I cannot do any recreation activities at all.

Total



**ORTHOPEDIC
PARTNERS**
Formerly Norwich Orthopedic Group
EST. 1957

Daniel Glenney, M.D.

Date: _____

Date of Injury: _____

Patricia Stuart, M.D.

Patient: _____

Place of Injury: _____

Kenneth Paonessa, M.D.

Michael Halperin, M.D.

Provider: _____

Work Related? ___ Yes / ___ No

Gabriel Abella, M.D.

Account #: _____

Auto Accident: ___ Yes / ___ No

Mohammad Pasha, M.D.

Insurance: _____

ID: _____

Tarik Kardestuncer, M.D.

Subscriber: _____

Ammar Anbari, M.D.

Nicole Arcand, M.D.

If your care is the result of an auto accident, please check one of the below:

Scott Stanat, M.D.

_____ I have Med Pay on my Auto Policy (this means the auto insurance pays as your primary insurance)

Richard Thoms, M.D.

Steven Wei, M.D.

_____ I have no Auto Med Pay Insurance (this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Jonathan Piposar, M.D.

Emily Vafek, M.D.

Nimit Patel, M.D.

Are you pursuing legal action against another party? ___ Yes / ___ No

Tammie Simao, CMPE,
CEO

What did you injure? (example: left arm) _____

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including how and where it occurred as required by your insurance:

Signature _____ Witnessed _____