



ORTHOPEDIC PARTNERS

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

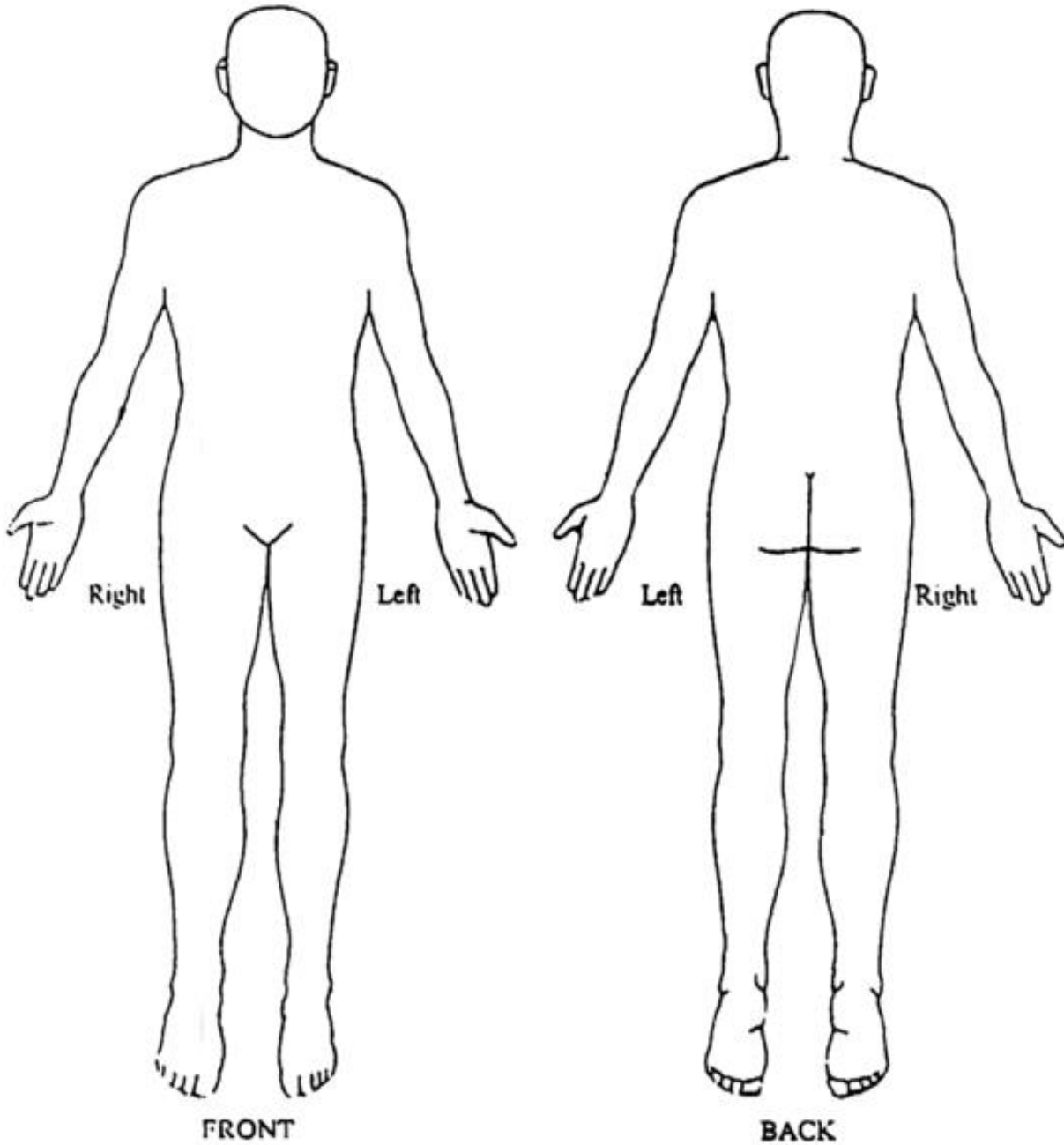
My Job Title Is: _____

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 /////



OWESTRY LOW BACK PAIN SCALE

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

No pain = 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.

<p>Section 1—Pain Intensity</p> <p><input type="checkbox"/> 0—The pain comes and goes and is very mild.</p> <p><input type="checkbox"/> 1—The pain in mild and does not vary much.</p> <p><input type="checkbox"/> 2—The pain come and goes and is moderate.</p> <p><input type="checkbox"/> 3—The pain is moderate and does not vary much.</p> <p><input type="checkbox"/> 4—The pain comes and does and is severe.</p> <p><input type="checkbox"/> 5—The pain in severe and does not vary much.</p>	<p>Section 2—Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> 0—I would not have to change my way of washing or dressing in order to avoid pain.</p> <p><input type="checkbox"/> 1—I do not normally change my way of washing or dressing even though it causes some pain.</p> <p><input type="checkbox"/> 2—Washing and dressing increase the pain but I manage not to change my way of doing it.</p> <p><input type="checkbox"/> 3—Washing and dressing increase the pain and I find it necessary to change my way of doing it.</p> <p><input type="checkbox"/> 4—Because of the pain I am unable to do some washing and dressing without help.</p> <p><input type="checkbox"/> 5—Because of the pain I am unable to do any washing or dressing without help.</p>
<p>Section 3—Lifting</p> <p><input type="checkbox"/> 0—I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> 1—I can lift heavy weights but it gives extra pain.</p> <p><input type="checkbox"/> 2—Pain prevents me lifting heavy weights off the floor.</p> <p><input type="checkbox"/> 3—Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.</p> <p><input type="checkbox"/> 4—Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> 5—I can only lift very light weights at most.</p>	<p>Section 4—Walking</p> <p><input type="checkbox"/> 0—I have no pain on walking.</p> <p><input type="checkbox"/> 1—I have some pain on walking but it does not increase with distance.</p> <p><input type="checkbox"/> 2—I cannot walk more than 1 mile without in creasing pain.</p> <p><input type="checkbox"/> 3—I cannot walk more than 1/2 mile without in creasing pain.</p> <p><input type="checkbox"/> 4—I cannot walk more than 1/4 mile without in creasing pain.</p> <p><input type="checkbox"/> 5—I cannot walk at all without increasing pain.</p>
<p>Please continue on page 2.</p>	

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

<p>Section 5—Sitting</p> <p><input type="checkbox"/> 0—I can sit in any chair as long as I like.</p> <p><input type="checkbox"/> 1—I can sit only in my favorite chair as long as I like.</p> <p><input type="checkbox"/> 2—Pain prevents me from sitting more than 1 hour.</p> <p><input type="checkbox"/> 3—Pain prevents me from sitting more than 1/2 hour.</p> <p><input type="checkbox"/> 4—Pain prevents me from sitting more than 10 minutes.</p> <p><input type="checkbox"/> 5—I avoid sitting because it increases pain immediately.</p>	<p>Section 6—Standing</p> <p><input type="checkbox"/> 0—I can stand as long as I like without pain.</p> <p><input type="checkbox"/> 1—I have some pain on standing but it does not increase with time.</p> <p><input type="checkbox"/> 2—I cannot stand for more than 1 hour without increasing pain.</p> <p><input type="checkbox"/> 3—I cannot stand for more than 1/2 hour without increasing pain.</p> <p><input type="checkbox"/> 4—I cannot stand for more than 10 minutes without increasing pain,</p> <p><input type="checkbox"/> 5—I avoid standing because it increases pain immediately.</p>
<p>Section 7—Sleeping</p> <p><input type="checkbox"/> 0—I get no pain in bed.</p> <p><input type="checkbox"/> 1—I get pain in bed but it does not prevent me from sleeping well.</p> <p><input type="checkbox"/> 2—Because of pain my normal nights sleep is reduced by less than one-quarter.</p> <p><input type="checkbox"/> 3—Because of pain my normal nights sleep is reduced by one-half.</p> <p><input type="checkbox"/> 4—Because of pain my normal nights sleep is reduced by less than three-quarters.</p> <p><input type="checkbox"/> 5—Pain prevents me from sleeping at all.</p>	<p>Section 8—Social</p> <p><input type="checkbox"/> 0—My social life is normal and gives me no pain.</p> <p><input type="checkbox"/> 1—My social life is normal but it increases the degree of pain.</p> <p><input type="checkbox"/> 2—Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.</p> <p><input type="checkbox"/> 3—Pain has restricted my social life and I do not go out very often.</p> <p><input type="checkbox"/> 4—Pain has restricted my social life to my home.</p> <p><input type="checkbox"/> 5—I have hardly any social life because of the pain.</p>
<p>Section 9—Traveling</p> <p><input type="checkbox"/> 0—I get no pain when traveling.</p> <p><input type="checkbox"/> 1—I get some pain when traveling but none of my usual forms of travel make it worse.</p> <p><input type="checkbox"/> 2—I get extra pain while traveling but it does not compel me to seek alternate forms of travel.</p> <p><input type="checkbox"/> 3—I get extra pain while traveling which compels to seek alternative forms of travel.</p> <p><input type="checkbox"/> 4—Pain restricts me to short necessary journeys under 1/2 hour.</p> <p><input type="checkbox"/> 5—Pain restricts all forms of travel.</p>	<p>Section 10—Changing Degree of Pain</p> <p><input type="checkbox"/> 0—My pain is rapidly getting better.</p> <p><input type="checkbox"/> 1—My pain fluctuates but is definitely getting better.</p> <p><input type="checkbox"/> 2—My pain seems to be getting better but improvement is slow.</p> <p><input type="checkbox"/> 3—My pain is neither getting better or worse.</p> <p><input type="checkbox"/> 4—My pain is gradually worsening.</p> <p><input type="checkbox"/> 5—My pain is rapidly worsening.</p>

Total:



ORTHOPEDIC PARTNERS

Date: _____ Date of Injury: _____

Patient: _____ Place of Injury: _____

Provider: _____ Work Related? _____ Yes / _____ No

Account #: _____ Auto Accident: _____ Yes / _____ No

Insurance: _____ ID: _____

Subscriber: _____

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

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

_____ 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)

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

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 _____

(860) 889-7345

(860) 963-2133

82 New Park Avenue
North Franklin, CT 06254

11 Industrial Park Road
Niantic, CT 06357

35 Kennedy Drive
Putnam, CT 06260

5 Founders Steet
Willimantic, CT 06226