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

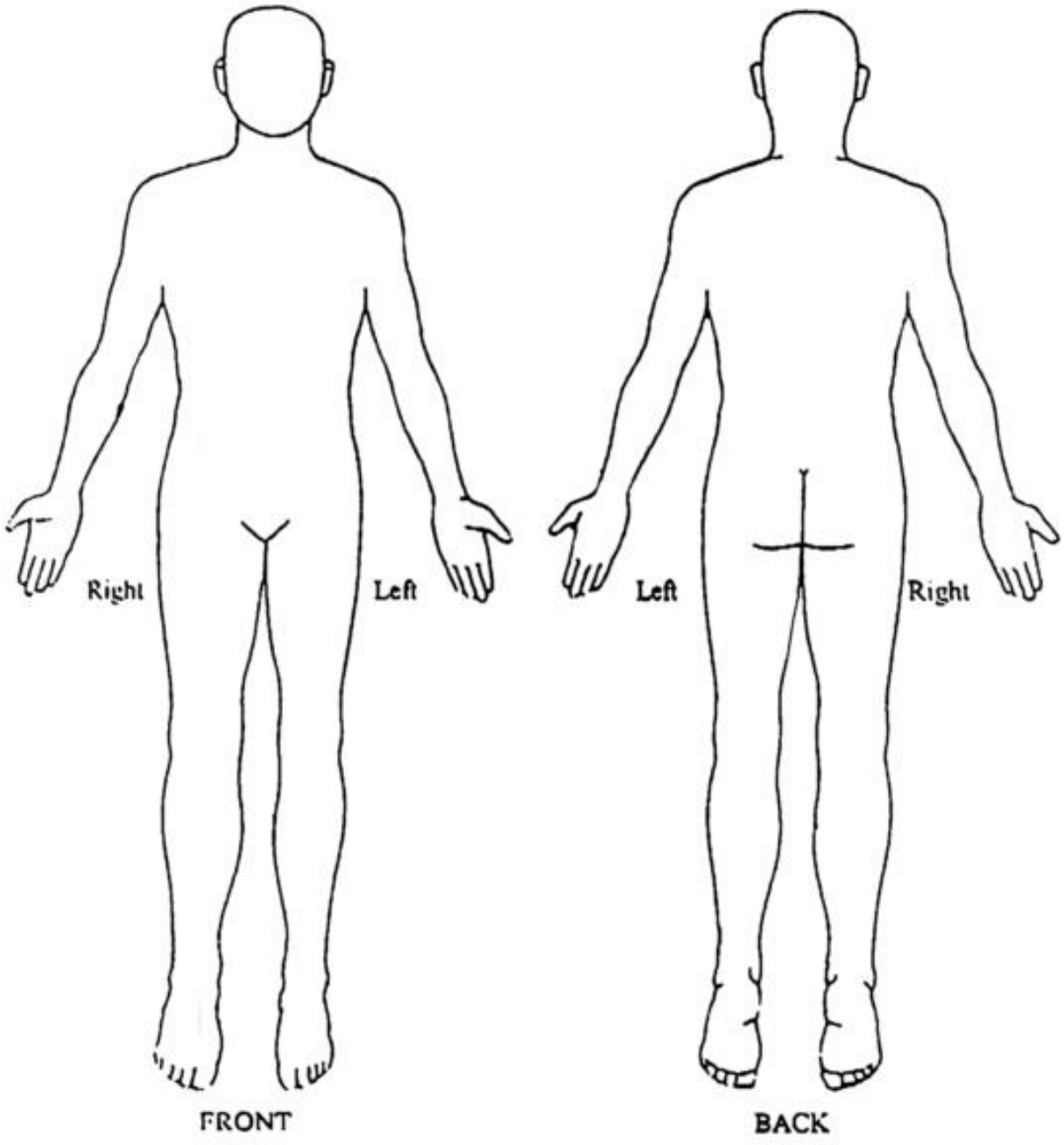
My Job Title Is:_____

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 NECK 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. ☒

Section 1—Pain Intensity

- ☐ 0—I have no pain at the moment.
- ☐ 1—The pain in 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 I 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 positioned, 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 headache 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 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 my in 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 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 then 1 hour sleepless).
- ☐ 2—My sleep in 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 (2-3 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 my neck.
- ☐ 3—I am able to engage in a few of my usual activities because of the pain in my neck.
- ☐ 4—I can hardly do any recreation activities because of the pain in my neck.
- ☐ 5—I cannot do any recreation activities at all.

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 <u>how</u> and <u>where</u> it occurred as required by your insurance:

_____

_____

_____

Signature _____ Witnessed _____

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