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

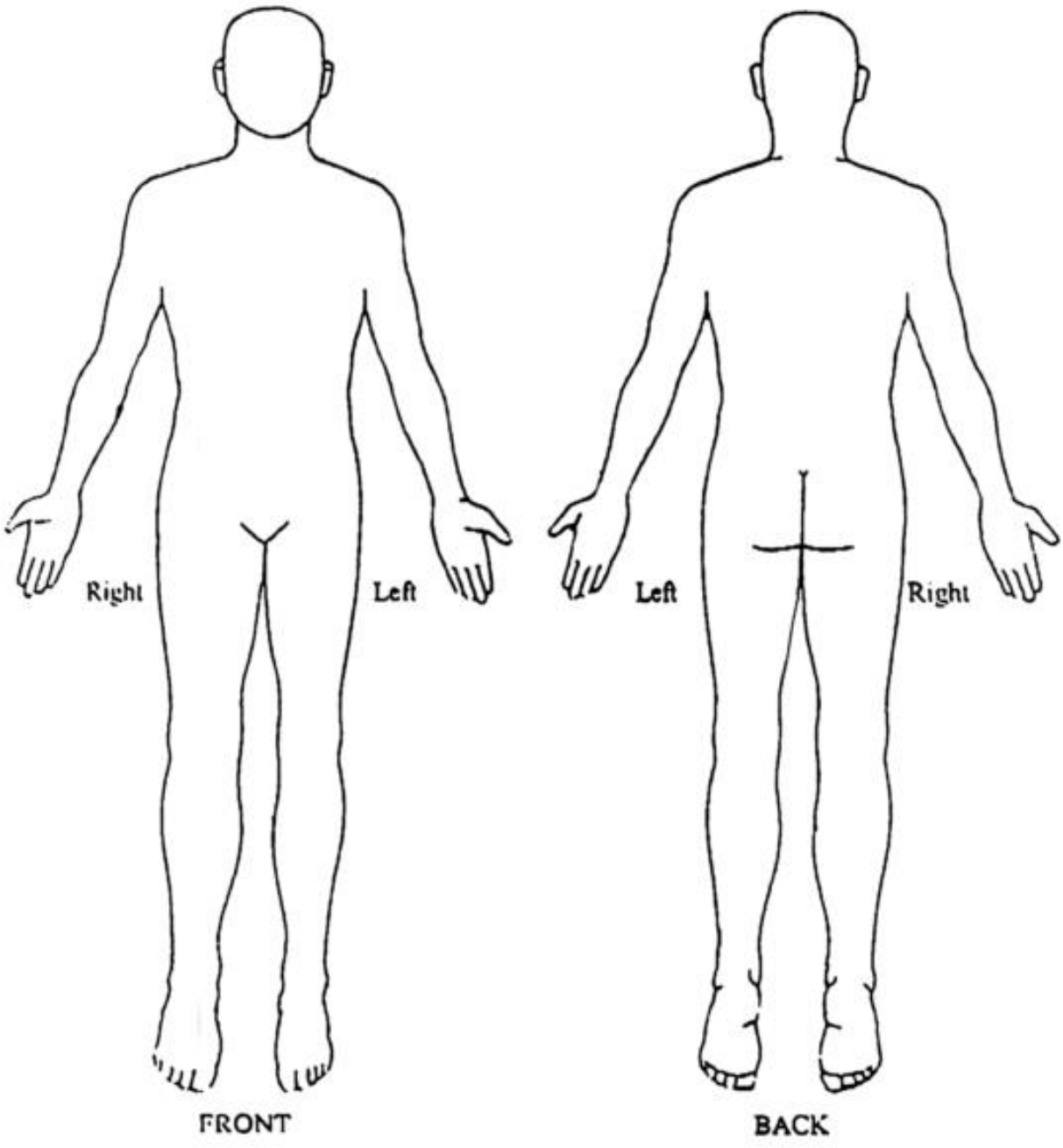
My Job Title Is:_____

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. ☒

Section 1—Pain Intensity

- ☐ 0—The pain comes and goes and is very mild.
- ☐ 1—The pain in mild and does not vary much.
- ☐ 2—The pain come and goes and is moderate.
- ☐ 3—The pain is moderate and does not vary much.
- ☐ 4—The pain comes and does and is severe.
- ☐ 5—The pain in severe and does not vary much.

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

- ☐ 0—I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ 1—I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ 2—Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ 3—Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ 4—Because of the pain I am unable to do some washing and dressing without help.
- ☐ 5—Because of the pain I am unable to do any washing or dressing without help.

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.
- ☐ 3—Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ 4—Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ 5—I can only lift very light weights at most.

Section 4—Walking

- ☐ 0—I have no pain on walking.
- ☐ 1—I have some pain on walking but it does not increase with distance.
- ☐ 2—I cannot walk more than 1 mile without in creasing pain.
- ☐ 3—I cannot walk more than 1/2 mile without in creasing pain.
- ☐ 4—I cannot walk more than 1/4 mile without in creasing pain.
- ☐ 5—I cannot walk at all without increasing pain.

Please continue on page 2.

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

Section 5—Sitting

- ☐ 0—I can sit in any chair as long as I like.
- ☐ 1—I can sit only in my favorite chair as long as I like.
- ☐ 2—Pain prevents me from sitting more than 1 hour.
- ☐ 3—Pain prevents me from sitting more than 1/2 hour.
- ☐ 4—Pain prevents me from sitting more than 10 minutes.
- ☐ 5—I avoid sitting because it increases pain immediately.

Section 6—Standing

- ☐ 0—I can stand as long as I like without pain.
- ☐ 1—I have some pain on standing but it does not increase with time.
- ☐ 2—I cannot stand for more than 1 hour without increasing pain.
- ☐ 3—I cannot stand for more than 1/2 hour without increasing pain.
- ☐ 4—I cannot stand for more than 10 minutes without increasing pain,
- ☐ 5—I avoid standing because it increases pain immediately.

Section 7—Sleeping

- ☐ 0—I get no pain in bed.
- ☐ 1—I get pain in bed but it does not prevent me from sleeping well.
- ☐ 2—Because of pain my normal nights sleep is reduced by less than one-quarter.
- ☐ 3—Because of pain my normal nights sleep is reduced by one-half.
- ☐ 4—Because of pain my normal nights sleep is reduced by less then three-quarters.
- ☐ 5—Pain prevents me from sleeping at all.

Section 8—Social

- ☐ 0—My social life is normal and gives me no pain.
- ☐ 1—My social life is normal but it increases the degree of pain.
- ☐ 2—Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ 3—Pain has restricted my social life and I do not go out very often.
- ☐ 4—Pain has restricted my social life to my home.
- ☐ 5—I have hardly any social life because of the pain.

Section 9—Traveling

- ☐ 0—I get no pain when traveling.
- ☐ 1—I get some pain when traveling but none of my usual forms of travel make it worse.
- ☐ 2—I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ 3—I get extra pain while traveling which compels to seek alternative forms of travel.
- ☐ 4—Pain restricts me to short necessary journeys under 1/2 hour.
- ☐ 5—Pain restricts all forms of travel.

Section 10—Changing Degree of Pain

- ☐ 0—My pain is rapidly getting better.
- ☐ 1—My pain fluctuates but is definitely getting better.
- ☐ 2—My pain seems to be getting better but improvement is slow.
- ☐ 3—My pain is neither getting better or worse.
- ☐ 4—My pain is gradually worsening.
- ☐ 5—My pain is rapidly worsening.

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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