



# 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

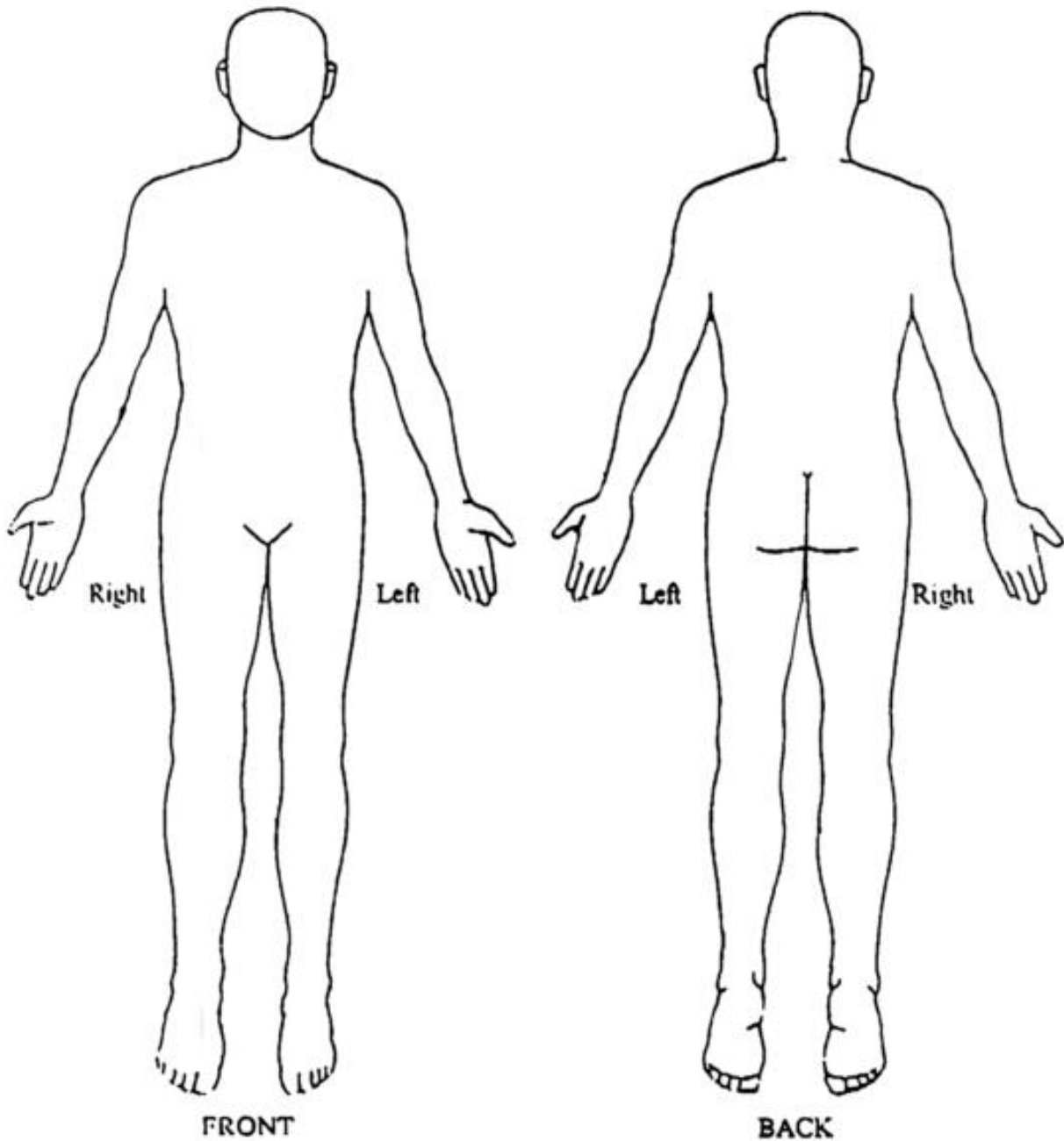
My Job Title Is: \_\_\_\_\_

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 is 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 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 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 (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 how and where it occurred as required by your insurance:**

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Signature \_\_\_\_\_ Witnessed \_\_\_\_\_

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