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Dear Patient,

We would appreciate your taking the time to fill out the attached forms. Your answers are important to our understanding of your problem(s) and will guide us in your case. These forms may take 25-30 minutes to complete; they need to be completed before your visit and brought with you to your scheduled appointment. Please do not mail them to us as they may not reach us in time for your appointment.

Your response to the questions will be held in the strictest confidence. It is important to answer each question. If you are not sure how to answer a question, please give the best answer you can and then make an additional comment in the margin. This information is very important in making the correct diagnosis, aids in a more accurate examination and minimizes any delay in treatment. Failure to complete the forms before your appointment may result in rescheduling your visit.

Please send or bring any relevant X-RAYS, MRI(s), CAT SCAN(s), MYELOGRAMS (s), EMG(s), NCS and copies of YOUR medical records from other physicians that may relate to your spine.

Thank you for your time and completeness. We look forward to meeting you.

Sincerely,

Your Spine Team

Gregory McDowell, MD Anthony Roccisano, DO Alan Dacre, M.D.

Jennifer Kuhr PA-C Jenna Nickels, PA-C Diana Kovach, PA-C



Dr _____ Date _____

Patient Name _____

Patient # _____

PEDIATRIC DEFORMITY DATABASE

Please List the doctors you have seen in the last year relating to your back pain.

<u>Type of Doctor</u>	<u>Doctors Name</u>	<u>Location (city/town)</u>
Chiropractor	_____	_____
Neurologist	_____	_____
Internist/Family	_____	_____
Surgeon	_____	_____
Physiatrist (Rehab)	_____	_____
Pain Clinic Doctor	_____	_____

History of Present Illness

What kind of spinal deformity have you noticed?

When was it first noticed?

Previous spine surgeries (only on back)

Surgery	Surgeon	Location	Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Birth History

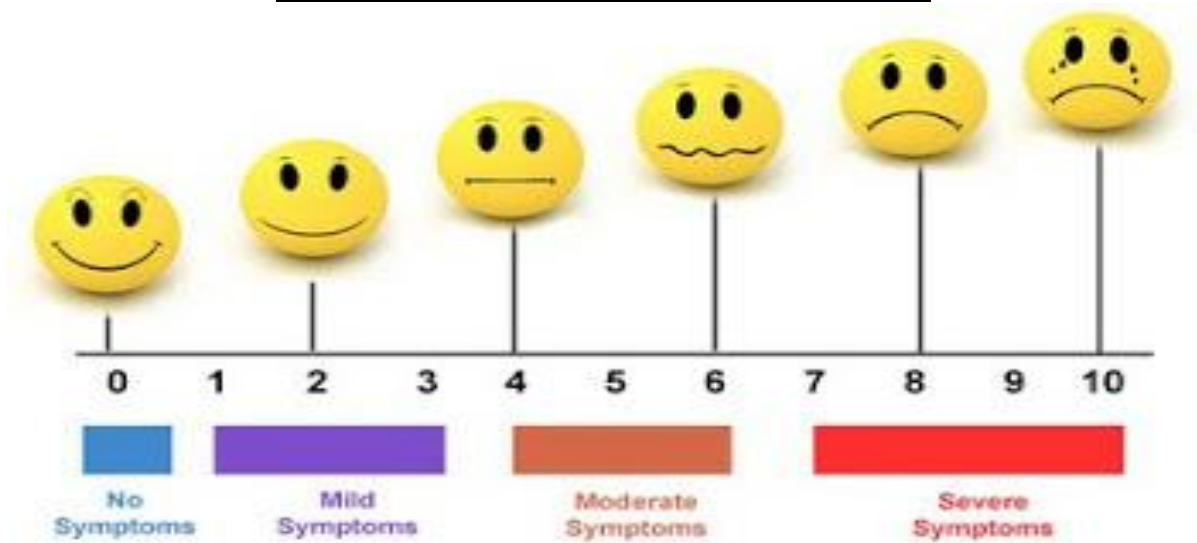
Any Complications?

Normal birth? Y / N

Do you have headaches? Y / N

Do you have back or neck pain? Y / N

Universal Pain Assessment Tool



1-3: Pain is **tolerable** and does **NOT** limit activities

4-6: Pain is **distressing** and I am unable to do **SOME** activities because of pain

7-10: Pain is **unbearable** and I am unable to do **ANY** activity because of pain

Please use the scale below to help you rate your average pain over the last week.

Document your number at the bottom of the following page. *Do not write on this page.*

- 0 Pain free.
- 1 Very minor annoyance. (You experience an occasional and minor twinge.)
- 2 Minor annoyance. (You experience an occasional yet strong twinge.)
- 3 Annoying enough to be distracting.
- 4 Can be ignored if you are really involved in your work (but still distracting.)
- 5 Cannot be ignored for more than 30 minutes.
- 6 Cannot be ignored for any length of time.
- 7 Makes it difficult to concentrate and interferes with sleep. (You are able to function with effort.)
- 8 Physical activity is severely limited. (You are able to read and converse with effort. Nausea and dizziness set in as factors of pain.)
- 9 Crying out or moaning uncontrollably; near delirium.
- 10 Unconscious or pain that makes you want to pass out.



Patient Name _____

Date of Birth _____ Patient # _____

PATIENT PAIN DIAGRAM

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the 5 different symbols. Include all affected areas.

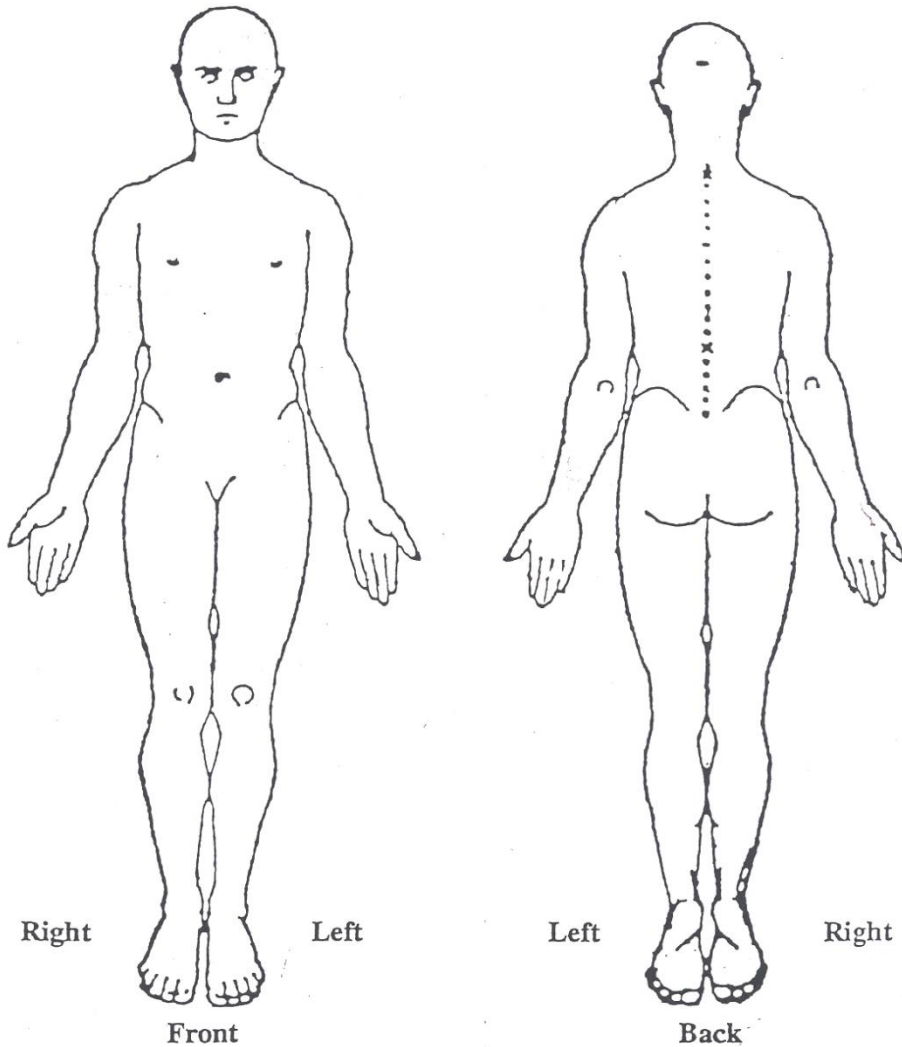
Aching
△ △ △

Numbness
= = =

Pins and needles
○ ○ ○

Burning
× × ×

Stabbing
/ / /



Please circle a number on the scale below relating to how bad your pain is on average over the last 7 days without pain medications.

Neck pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Arm pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Back pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain
Leg pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain



Patient Name _____

Date of Birth _____ Patient # _____

Check recent studies done for your back.

Imaging for back

Where was the study done?

When?

	Regular X-Rays		
	CAT Scan		
	MRI		
	Bone Scan		
	Myelogram		
	EMG/Nerve Studies		
	Discogram		
	Laboratory Studies		

Below, mark the Treatment and the Effect of Treatment. If you tried other treatment not mentioned, write them in on the bottom and their effect.

<u>Treatment</u>	<u>Helped</u>	<u>Worsened</u>	<u>No Change</u>
_____ Physical Therapy _____ #weeks	_____	_____	_____
_____ Hot/Cold Pack	_____	_____	_____
_____ Exercise	_____	_____	_____
_____ Bed rest	_____	_____	_____
_____ TENS unit for home use	_____	_____	_____
_____ Massage	_____	_____	_____
_____ Chiropractic _____ #visits	_____	_____	_____
_____ Osteopathic manipulation	_____	_____	_____
_____ Biofeedback	_____	_____	_____
_____ Local (trigger point) injection	_____	_____	_____
_____ Epidural injection How many? _____	_____	_____	_____
_____ Facet joint injection	_____	_____	_____
_____ Pelvic traction	_____	_____	_____
_____ Soft back brace	_____	_____	_____
_____ Rigid back brace	_____	_____	_____
_____ Acupuncture	_____	_____	_____
_____ Aspirin	_____	_____	_____
_____ Tylenol	_____	_____	_____
_____ Motrin, Advil, or other NSAIDS	_____	_____	_____
_____ Pain killers (how often? _____)	_____	_____	_____
_____ Steroid dose pack	_____	_____	_____
_____ Muscle relaxant medication	_____	_____	_____
_____ Anti-depressant medication	_____	_____	_____
_____ Lyrica/Neurontin	_____	_____	_____
_____ Other: _____	_____	_____	_____