LONGVIEW ORTHOPAEDIC
CLINIC ASSOCIATION
Personalized Medicine. Quality Care.

TELEPHONE 903-758-2746 • FAX 903-758-7127

SPINE PATIENT ENCOUNTER FORM

NAME:_____ DATE:_____

1. WHAT KIND OF PAIN ARE YOU HAVING? (CHECK ALL THAT APPLY)	PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING. (CHECK ALL THAT APPLY)					RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN. (CIRCLE)									
	Sharp	Dull	Aching	Stabbing	Throbbing										
☐ BACK PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10
☐ NECK PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10
☐ LEFT LEG PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10
☐ RIGHT LEG PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10
☐ LEFT ARM PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10
☐ RIGHT ARM PAIN	☐	☐	☐	☐	☐	1	2	3	4	5	6	7	8	9	10

2. HOW LONG HAVE YOU BEEN HAVING PAIN? _____DAYS_____WEEKS _____MONTHS _____YEARS

3.

WHAT IS THE RATIO OF BACK TO LEG PAIN?
- ☐ 100% BACK / 0% LEG PAIN
- ☐ 75% BACK / 25% LEG
- ☐ 50% BACK / 50% LEG PAIN
- ☐ 25% BACK / 75% LEG PAIN
- ☐ 0% BACK / 100% LEG PAIN
- ☐ NO BACK / LEG PAIN

WHAT IS THE RATIO OF NECK TO ARM PAIN?
- ☐ 100% NECK / 0% ARM PAIN
- ☐ 75% NECK / 25% ARM PAIN
- ☐ 50% NECK / 50% ARM PAIN
- ☐ 25% NECK / 75% ARM PAIN
- ☐ 0% NECK / 100% ARM PAIN
- ☐ NO NECK / ARM PAIN

4. ARE YOUR SYMPTOMS DUE TO AN INJURY? ☐ YES ☐ NO
IF THE ANSWER IS YES, PLEASE GIVE DATE AND EXPLAIN THE DETAILS REGARDING THE INJURY:

_____

_____

_____

5. IF YOU ARE SUFFERING FROM BACK OR NECK PAIN, WHAT PERCENTAGE OF THE PAIN IS RELIEVED WHEN LYING DOWN IN YOUR MOST COMFORTABLE POSITION?
- ☐ 100% RELIEF WHEN LYING DOWN
- ☐ 75% RELIEF WHEN LYING DOWN
- ☐ 50% RELIEF WHEN LYING DOWN
- ☐ 25% RELIEF WHEN LYING DOWN
- ☐ 0% RELIEF WHEN LYING DOWN

6. WHAT POSITIONS AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)
- ☐ STANDING
- ☐ WALKING
- ☐ SITTING
- ☐ FORWARD BENDING
- ☐ BACKWARD BENDING
- ☐ SIDE BENDING
- ☐ GETTING OUT OF BED

7. PLEASE DESCRIBE YOUR WALKING TOLERANCE:
- ☐ I CAN WALK INDEFINITELY.
- ☐ I CAN WALK UP TO AN HOUR.
- ☐ I CAN WALK UP TO 30 MINUTES.
- ☐ I CAN WALK UP TO ... MINUTES.
- ☐ I CAN WALK LESS THAN 5 MINUTES

8. HAVE YOU NOTICED ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ☐ CLUMSINESS
- ☐ DROPPING OBJECTS MORE FREQUENTLY
- ☐ WORSENING HANDWRITING
- ☐ UNSTEADY WHEN WALKING
- ☐ NONE OF THE ABOVE

9. HAVE YOU NOTICED ANY CHANGE IN YOUR BODY SHAPE RECENTLY? ☐ YES ☐ NO

IF YES, THEN OVER WHAT TIME PERIOD?_____

10. WHAT TREATMENTS HAVE YOU HAD FOR YOUR SYMPTOMS? (CHECK ALL THAT APPLY)

	DID THE TREATMENT HELP?	
☐ PHYSICAL THERAPY	☐ YES	☐ NO
☐ EPIDURAL STEROID INJECTIONS	☐ YES	☐ NO
☐ FACET BLOCKS	☐ YES	☐ NO
☐ NSAIDS (MOTRIN. IBUPROFIN, CELBREX. BEXTRA, VIOXX. LODINE. ETC.)	☐ YES	☐ NO
☐ NARCOTICS (LORTAB, DARVOCET. VICODIN, PERCOCET, OXYCONTIN, ETC.)	☐ YES	☐ NO
☐ ULTRA/ ULTRACET	☐ YES	☐ NO
☐ CHIROPRACTOR MANIPULATION	☐ YES	☐ NO
☐ BRACES	☐ YES	☐ NO

11. HAVE YOU HAD ANY PREVIOUS SPINE SURGERIES? ☐ YES ☐ NO

IF YES, PLEASE LIST THE NAME OF THE PROCEDURE. THE DATE AND THE SURGEON:

_____

_____

_____

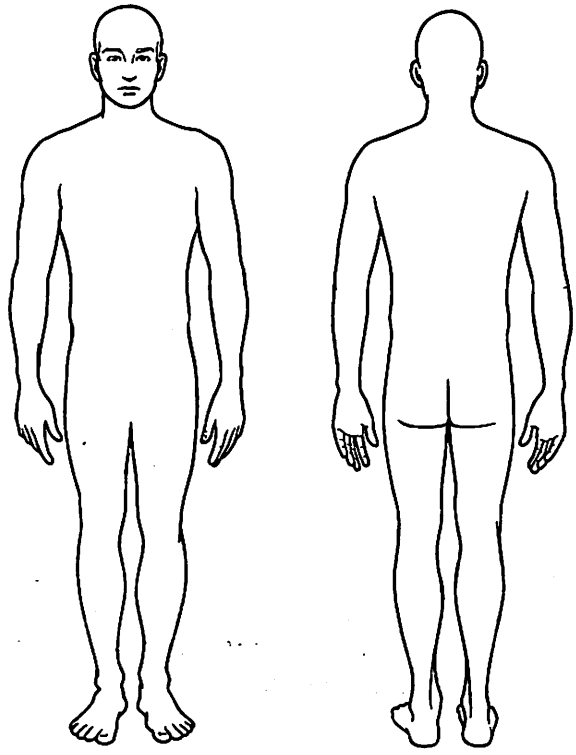
12. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ☐ FEVERS
- ☐ CHILLS
- ☐ NIGHT SWEATS
- ☐ WEIGHT LOSS
- ☐ NONE OF THE ABOVE

13. DOES THE PAIN WAKE YOU UP FROM SLEEP AT NIGHT? ☐ YES ☐ NO

14. HAVE YOU EVER LOST BOWEL OR BLADDER CONTROL? ☐ YES ☐ NO

15. PLEASE SHADE IN THE AREAS ON THE DIAGRAMS THAT CORRESPOND TO YOUR AREAS OF PAIN ON YOUR BODY.



LONGVIEW ORTHOPAEDIC CLINIC

MODIFIED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE[1]

Section 1: To be completed by patient

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of days of back pain: _____ (this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the line which most closely describes your current condition.**

Pain Intensity

_____The pain is mild and comes and goes.
_____The pain is mild and does not vary much.
_____The pain is moderate and comes and goes.
_____The pain is moderate and does not vary much.
_____The pain is severe and comes and goes.
_____The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.)

_____I do not have to change the way I wash and dress myself to avoid pain.
_____I do not normally change the way I wash or dress myself even though it causes some pain.
_____Washing and dressing increases my pain, but I can do it without changing my way of doing it.
_____Washing and dressing increases my pain, and I find it necessary to change the way I do it.
_____Because of my pain I am partially unable to wash and dress without help.
_____Because of my pain I am completely unable to wash or dress without help.

Lifting

_____I can lift heavy weights without increased pain.
_____I can lift heavy weights but it causes increased pain
_____Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned (ex. on a table, etc.).
_____Pain prevents me from lifting heavy weights off of the floor, but I can manage light to medium weights if they are conveniently positioned.
_____I can lift only very light weights.
_____I can not lift or carry anything at all.

Walking

_____I have no pain when walking.
_____I have pain when walking, but I can still walk my required normal distances.
_____Pain prevents me from walking long distances.
_____Pain prevents me from walking intermediate distances.
_____Pain prevents me from walking even short distances.
_____Pain prevents me from walking at all.

Sitting

_____Sitting does not cause me any pain.
_____I can only sit as long as I like providing that I have my choice of seating surfaces.
_____Pain prevents me from sitting for more than 1 hour.
_____Pain prevents me from sitting for more than 1/2 hour.
_____Pain prevents me from sitting for more than 10 minutes.
_____Pain prevents me from sitting at all.

Section 2 (con't): To be completed by patient

Standing

_____I can stand as long as I want without increased pain.
_____I can stand as long as I want but my pain increases with time.
_____Pain prevents me from standing more than 1 hour.
_____Pain prevents me from standing more than 1/2 hour.
_____Pain prevents me from standing more than 10 minutes.
_____I avoid standing because it increases my pain right away.

Sleeping

_____I get no pain when I am in bed.
_____I get pain in bed, but it does not prevent me from sleeping well.
_____Because of my pain, my sleep is only 3/4 of my normal amount.
_____Because of my pain, my sleep is only 1/2 of my normal amount.
_____Because of my pain, my sleep is only 1/4 of my normal amount.
_____Pain prevents me from sleeping at all.

Social Life

_____My social life is normal and does not increase my pain.
_____My social life is normal, but it increases my level of pain.
_____Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
_____Pain prevents me from going out very often.
_____Pain has restricted my social life to my home.
_____I have hardly any social life because of my pain.

Traveling

_____I get no increased pain when traveling.
_____I get some pain while traveling, but none of my usual forms of travel make it any worse.
_____I get increased pain while traveling, but it does not cause me to seek alternative forms of travel.
_____I get increased pain while traveling which causes me to seek alternative forms of travel.
_____My pain restricts all forms of travel except that which is done while I am lying down.
_____My pain restricts all forms of travel.

Employment/Homemaking

_____My normal job/homemaking activities do not cause pain.
_____My normal job/homemaking activities increase my pain, but I can still perform all that is required of me.
_____I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
_____Pain prevents me from doing anything but light duties.
_____Pain prevents me from doing even light duties.
_____Pain prevents me from performing any job or homemaking chores.

Section 3: To be completed by physical therapist/provider

SCORE: Initial_____% Subsequent_____% Subsequent_____% Discharge_____%

Number of treatment sessions: _____

Diagnosis/ICD-9 Code: _____

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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

NAME: _____ DATE: _____ SCORE: _____

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CONFIDENTIAL INFORMATION

THIS FORM IS SO THAT DR. OGUNSEINDE WILL BE AWARE IF THE PATIENT IS ALREADY A PATIENT WITH A PAIN MANAGEMENT DOCTOR.

THANK YOU

PATIENT NAME: _____

DOB: _____

DATE: _____

DOES THE PATIENT ALREADY HAVE A PAIN MANAGEMENT DOCTOR

YES _____ **NO** _____

IF YOU ANSWERED YES TO THE ABOVE QUESTION PLEASE GIVE THE NAME AND PHONE NUMBER OF THE DOCTOR AND WHERE THEY ARE LOCATED:

_____

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PATIENT PARTICIPATION AND CONTROLLED SUBSTANCE AGREEMENT

The following is an agreement which outlines my responsibilities as a patient who is receiving controlled substance (narcotic) pain medications. I understand that this agreement **does not guarantee** that I will receive narcotics or any other medication from Dr. Ogunseinde; however, it simply states that if Dr. Ogunseinde chooses medication as part of my treatment, I will be obligated to follow the below policy.

1. I will use my narcotic pain medications only as directed. Narcotic pain medications will **only** be refilled or amended during **scheduled** appointments. No early refills will be granted. Prescriptions will not be phoned in to the pharmacy.
2. I will accept responsibility for my prescription for narcotic pain medications. Prescriptions will not be rewritten if lost or stolen, no matter what the reason.
3. I will not use illegal substances, street drugs, or abuse alcohol while taking controlled pain medication.
4. I will **not** use my narcotic pain medication as an emotional crutch (i.e. to get me through a stressful day, etc...). Medications are only to be used for my pain condition in the schedule my physician prescribed them to me.
5. I agree to a saliva swab test for compliance with schedule II drug use at any random time.

_____
Date

_____
Patient printed name

_____
Patient signature

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CONFIDENTIAL INFORMATION

Dr. Ogunseinde uses different specialty pharmacies for a compound pain cream and a scar cream if needed after surgery. If you received a phone call from one of these companies to discuss information with you then we did send them a script for this medication along with the patient information and insurance information. This is optional. You do not have to accept this medication.

_____
Patient name

_____
Patient signature

_____
Date