Date: _____ Acct #:_____

Advanced Spine Care of Texas

Texas Orthopaedic Surgical Associates

Spine Evaluation Form

Name:_____
Last First MI

Dominant Hand: R ☐ L ☐

Chief Complaint: Which part of your spine is your main concern today?

☐ Low back/Legs ☐ Neck/Arms ☐ Thoracic/ upper back

Onset of spine problem:

When did your current problem/symptoms begin?_____

_____

Describe onset and preceding events: _____

_____

_____

_____

Have your symptoms changed since onset? _____

Have you had prior episodes of this condition? _____

Is your problem the result of an on-the-job injury? ☐ Yes ☐ No

Estimated Date of Injury:_____

Pain Diagram:

Draw the exact **location and pattern** of your symptoms on your body where you **now feel** your **typical symptoms**. Include all affected areas. Use the appropriate symbols indicated below.

FRONT **BACK**

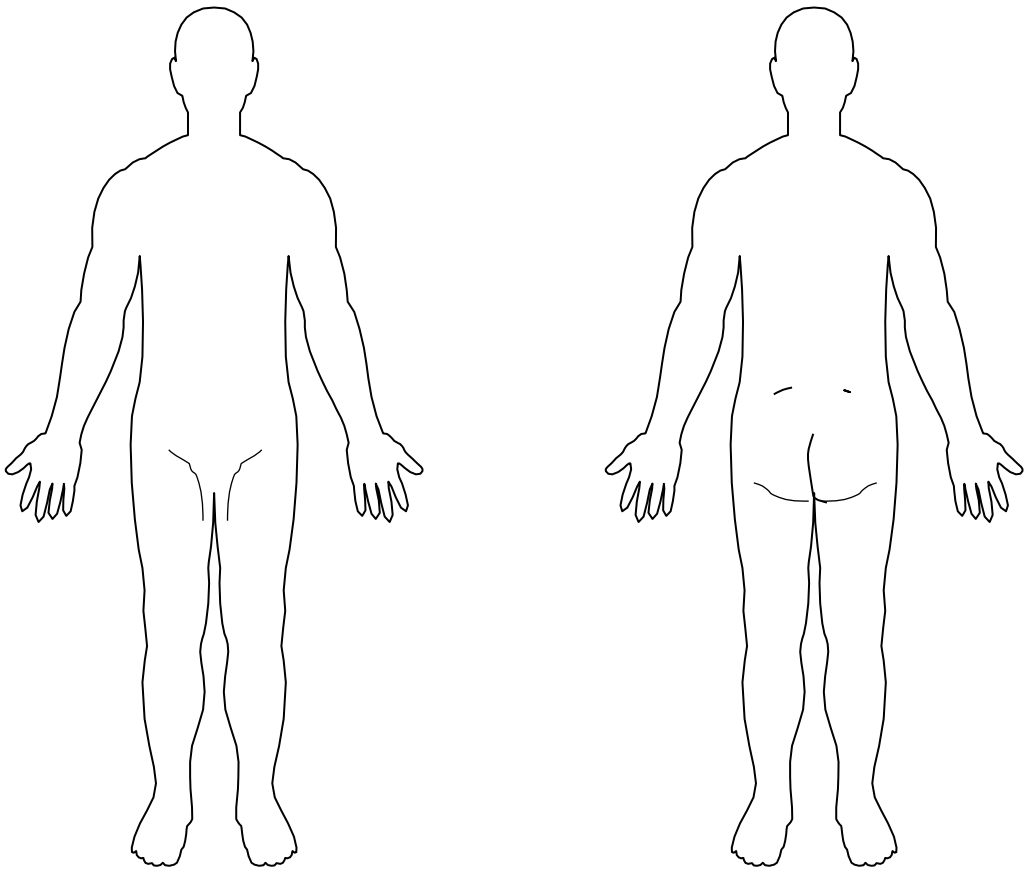
SYMBOLS:

ACHE
>>>>>
>>>>>

NUMBNESS
=====
=====

STABBING PAIN
///////
///////

PINS & NEEDLES
oooo
oooo



Date: _____ Acct #:_____

Pain Severity

If 10 is the worst pain imaginable and 0 is no pain at all, please note your pain over the last **TWO WEEKS:**

a) Please rate your **AVERAGE** amount of back/ neck pain: 0 1 2 3 4 5 6 7 8 9 10

b) Please rate your **AVERAGE** amount of leg/ arm pain: 0 1 2 3 4 5 6 7 8 9 10

What does each of the following activities do to your pain?

	No Change	Relieves Pain	Increases Pain	After how Long?
Sitting				
Walking				
Standing				
Lying Down				
Bending Forward				
Bending Backward				
Lifting				
Coughing/Sneezing				
Changing Positions				

Which other activities, motions, or positions affect your symptoms?_____

_____

What do you do to relieve your pain? _____

_____

Check all those that apply to you:

Bladder Function: ☐ Normal ☐ Loss of control or accidents ☐ Difficulty starting urination ☐ Sense of urgency

Bowel function: ☐ Normal ☐ Loss of control or accidents

Problems with sexual function?: ☐ No ☐ Yes

Loss of sensation around the groin, genitals or buttocks? ☐ No ☐ Yes

Weakness of a leg/foot? ☐ No ☐ Yes (☐ Right ☐ Left)

Weakness of arm/hand? ☐ No ☐ Yes (☐ Right ☐ Left)

Does your pain hurt only at night or awaken you at night? ☐ No ☐ Yes

Does you pain interfere with your sleep? ☐ No ☐ Yes

Previous Treatment, Consultation, or Tests for this spine problem:

	Effect of Treatment		
	Helped	**Made things worse**	**No difference**
☐ Massage	☐	☐	☐
☐ Physical therapy	☐	☐	☐
☐ Chiropractic therapy	☐	☐	☐
☐ Spinal injections, epidurals	☐	☐	☐

☐ Regular Xrays ☐ MRI ☐ Myelogram ☐ CT Scan

☐ Bone Scan ☐ EMG/NCV

Physicians seen: (Name, type of specialty, approx. dates) _____

_____

_____

Medications tried (list) _____

_____

Date: _____ Acct#:_____

Function:

Pain Intensity (Mark only one)
0 I can tolerate the pain I have without having to use pain killers
1 The pain is bad but I manage without taking pain killers
2 Pain killers give complete relief from pain
3 Pain killers give moderate relief from pain
4 Pain killers give very little relief from pain
5 Pain killers have no effect on the pain, I do not use them.

Personal Care (Washing, Dressing, etc.) (Mark only one)
0 I can look after myself normally without it 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 manage most of my personal care.
4 I need help everyday in most aspects of self care.
5 I do not get dressed, wash with difficulty and stay in bed.

Lifting (Mark only one)
0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it gives extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
4 I can lift only very light weights.
5 I cannot lift or carry anything at all.

Walking (Mark only one)
0 Pain does not prevent me from walking any distance.
1 Pain prevents me walking more than 1 mile.
2 Pain prevents me walking more than ½ mile.
3 Pain prevents me walking more than ¼ mile.
4 I can only walk using a stick or crutches.
5 I am in bed most of the time and have to crawl to the toilet.

Sitting (Mark only one)
0 I can sit in any chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting more than one hour.
3 Pain prevents me from sitting more than thirty minutes.
4 Pain prevents me fro sitting more than ten minutes.
5 Pain prevents me from sitting at all.

SCORE _____

Standing (Mark only one)
0 I can stand as long as I want without extra pain.
1 I can stand as long as I want but it gives extra pain.
2 Pain prevents me from standing more than one hour.
3 Pain prevents me from standing more than thirty minutes.
4 Pain prevents me from standing more than ten minutes.
5 Pain prevents me from standing at all.

Sleeping (Mark only one)
0 Pain does not prevent me from sleeping well.
1 I can sleep well only by using tablets.
2 Even when I take tablets I have less than six hours sleep.
3 Even when I take tablets I have less than four hours sleep.
4 Even when I take tablets I have less than two hours sleep.
5 Pain prevents me from sleeping at all.

Employment/Homemaking (Mark only one)
0 My normal homemaking/job activities do not cause pain.
1 My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2 I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
3 Pain prevents me from doing anything but light duties.
4 Pain prevents me from doing even light duties.
5 Pain prevents me from performing any job or homemaking chores.

Social Life (Mark only one)
0 My social life is normal and gives me no extra pain.
1 My social life is normal but 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 as often.
4 Pain has restricted my social life to home.
5 I have no social life because of pain.

Traveling (Mark only one)
0 I can travel anywhere without extra pain.
1 I can travel anywhere but It gives extra pain.
2 Pain is bad but I manage journeys over two hours.
3 Pain restricts me to journeys less than one hour.
4 Pain restricts me to short journeys under thirty minutes.
5 Pain prevents me from traveling except to the doctor or hospital.

Name: _____ Date:_____ Acct #:_____

Previous Spine Surgeries:

Type	Date	Surgeon	Pain better?

For younger patients with scoliosis:
Family history of scoliosis? _____
Family history of genetic disorders? _____
Growth over past year in inches? _____
For girls: have you begun periods yet and at what age? _____

Family Health History: Have your blood relatives had the following? If yes, explain which relative and type of condition.)

Multiple Sclerosis ☐ Yes_____

When was your last Physical Exam? _____ By whom: _____
Primary Care Physician: _____

Social History:

Education: How much have you completed?
☐ Less than high school ☐ HS diploma/GED ☐ Vocational school ☐ Some college
☐ College degree_____ ☐ Post graduate degree(s) _____

Stress: Have you had a stress or change in a significant relationship in the last year? Yes ☐ No ☐
If yes, please explain: _____

Patient Signature_____ Date_____

Physician's Signature_____ Date_____

Texas Orthopaedic Surgical Associates
Patient Amendments History

Vaccination Status
For patients 65 and older: Have you received a pneumonia vaccination?

Yes or No

Advance Care
Do you have a health care proxy in the event you are unable to make your own medical decisions?

Yes or No

Do you have a living will?

Yes or No

If yes, list designee and phone number

_____ _____
Designee Phone number

Which statement best reflects your wishes on advanced care recommendations?

___ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life

___ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart heart, even if it is necessary to save my life

___ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.