LEWISTON ORTHOPEDICS
A DIVISION OF CATALYST Medical Group
OWNED BY THE PHYSICIANS OF LEWISTON ORTHOPEDICS AND VALLEY MEDICAL CENTER

320 Warner Drive | Lewiston, ID 83501
(208) 743-3523 | (800) 841-3523 | Fax (208) 746-8741
www.lewistonortho.com
www.catalystmedicalgroup.com

Spine Form: Personal Health History

_____
Last Name First Name Middle Name

Referring Doctor: _____

Today's Date

Date of Birth: _____ Age: _____

ONSET
When did this most recent episode of back/neck pain begin? _____

Was your injury the result of one of the following?

____ Vehicle accident ____ Recreational accident ____ No known cause
____ On the job injury ____ Non-work-related incident

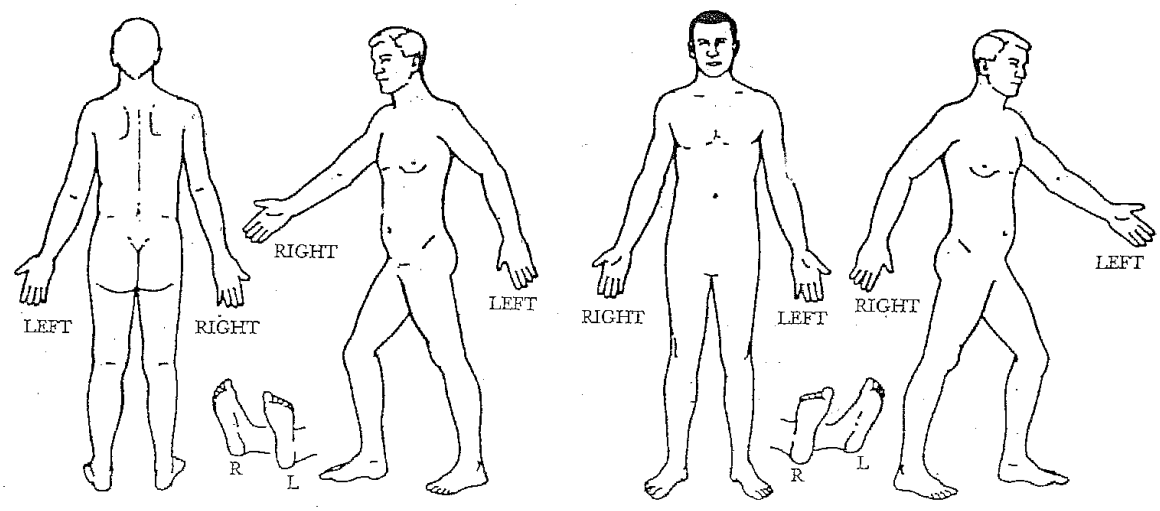
Please briefly describe the onset of your back/neck pain and the events which preceded onset: _____
_____
_____
_____

Do you feel this injury was your employer's or another person's fault: ____ Yes ____ No

CURRENT STATUS

Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below.

ACHE >>>>> NUMBNESS ===== PINS & NEEDLES +++++ STABBING /////
>>>>> ===== +++++ /////
>>>>> ===== +++++ /////



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Oswestry Pain Scale

Please rate the severity of your pain by circling a number below

No pain — Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Instructions: Please circle 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 is mild and does not vary much
2. The pain comes and goes and is moderate
3. The pain is moderate and does not vary much
4. The pain comes and goes and is severe
5. The pain is severe and does not vary much

Section 2- Personal Care
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 increases the pain but manage my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change the way I do it.
4. Because of pain I am unable to do some of my washing and dressing without help.
5. Because of pain I am unable to any washing and dressing without help

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

Section 4 – Walking
0. Pain does not prevent me from walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than ¼ mile
4. I can only use cane or crutches to walk
5. I cannot walk at all without increasing pain

Section 5- Sitting
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 1 hour
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting 10 minutes
5. Pain prevents me from sitting at all

Section 6- Standing
0. I can stand as long as I want without pain
1. I can stand as long as I want but it causes extra pain
2. Pain prevents me from standing 1 hour
3. Pain prevents me from standing 30 minutes
4. Pain prevents me from standing 10 minutes
5. Pain prevents me from standing at all.

Section 7- Sleeping
0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I sleep less than 6 hours
3. Because of pain I sleep less than 4 hours
4. Because of pain I sleep less than 2 hours
5. Pain prevents me from sleeping at all

Section 8- Social Life
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 effect on my social life apart from limiting my more energetic interests e.g. dancing, golfing
3. Pain has restricted may social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have hardly any social life because of pain

Section 9- Traveling
0. I have no pain when I travel
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but manage trips over 2 hours
3. I get extra pain while traveling which compels me to seeks other forms of travel
4. Pain restricts me to short necessary trips under 30 minutes
5. Pain restricts me from traveling except to receive treatment

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

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Patient's Name:_____ Date:_____

TREATMENT

Please list the physician, chiropractors, and/or osteopaths you have seen in the LAST YEAR for you back/neck pain, along with the approximate dates

TYPE OF DOCTOR	DOCTOR'S NAME	LOCATION	APPROXIMATE DATES

Put an "X" next to each type of treatment you have had for your back/neck pain in the past, and then put an "X" in the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them in at the bottom and indicate how they affected you.

TREATMENT	EFFECT OF TREATMENT		
	Helped	Made things worse	Didn't do much either way
____ Hot packs/ice/ultrasound	_____	_____	_____
____ Massage	_____	_____	_____
____ Electrical stimulation	_____	_____	_____
____ TENS Unit for home use	_____	_____	_____
____ Bed rest	_____	_____	_____
____ Chiropractic treatment	_____	_____	_____
____ Local (trigger point)	_____	_____	_____
____ Epidural injections	_____	_____	_____
____ Soft back brace	_____	_____	_____
____ Rigid back brace	_____	_____	_____
____ Acupuncture	_____	_____	_____
____ Other _____	_____	_____	_____

If you have had surgery on your back/neck (including chymopapain), please fill in the following for each operation:

DATE	TYPE OF SURGERY & SURGEON	PAIN AFTER SURGERY Worse	Same	Better	(M.D. USE ONLY)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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Patient's Name:_____ Date: _____

PREVIOUS BACK/NECK SURGERY

Have you had any previous back or neck symptoms severe enough to seek professional help other than the current problem?
____ Yes ____ No ____ Just those mentioned above

If yes, how long ago and briefly explain: _____
_____
_____

Were any of these previous episodes the result of any industrial injury or motor vehicle accident? ___ Yes ___ No
If yes, please explain: _____

OCCUPATIONAL HISTORY

Employer: _____Date of Hire: _____Usual occupation: _____
Are you currently working? _____
When was the last time you worked? _____

How many months have you worked during the last 24 months? _____

How satisfied are you with your job?
____ Very satisfied
____ Satisfied
____ Dissatisfied
____ It is the worst job I've ever had

Has your employer treated you fairly? ____ Yes ____ No ____N/A
If no, please explain: _____
_____
Has anyone in your family been on disability? ____ Yes ____ No
If yes, what is their relationship to you? _____

Does an attorney assist you with your injury claim? ____ Yes ____ No ____N/A

If yes, please explain briefly: _____
_____

I hereby confirm that the information provided here is accurate.

Patient Signature: _____ Date: _____

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