Virginia iSpine Physicians

PATIENT INFORMATION

Name (last) _____ (First) _____(M.I.) _____

Address _____City_____State_____Zip_____

(M/F) ____ Social Security No. _____ Date of Birth _____ Age _____

Preferred Phone # _____Work Phone#_____ Cell Phone# _____

Please check here to authorize VISP to send appointment reminders to your cell phone ____

Marital Status _____ Emergency Contact: _____ Relationship: _____

Phone#_____

Referring Physician: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

RESPONSIBLE PARTY

Guarantor's Name _____ E-mail: _____

Address _____

Patient Relation to Guarantor _____ Guarantor's Employer _____

Guarantor's Social Security No. _____Guarantor's Date of Birth _____(M/F) _____

PRIMARY INSURANCE

Name of Insurance Company _____

Subscriber's ID# _____ Group # _____

Subscriber's Name: _____Patient Relation to Subscriber: _____

Subscriber's Date of Birth: _____ (M/F) _____ Insurance Phone # _____

Insurance Address _____

SECONDARY INSURANCE

Name of Insurance Company _____

Subscriber's ID# _____ Group # _____

Subscriber's Name: _____Patient Relation to Subscriber: _____

Subscriber's Date of Birth: _____ (M/F) _____ Insurance Phone # _____

Insurance Address _____

PHARMACY INFORMATION

Whenever possible, Virginia iSpine Physicians, P.C. will electronically transmit your prescription(s) directly to your pharmacy.

Please provide us with your preferred pharmacy information in the space below

Pharmacy Name: _____ Phone Number:_____

Pharmacy Address: _____ City/State/Zip _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, including **urine drug screens** to monitor prescription and illicit drugs, all of which the judgment of the attending physician or their assigned designees may consider medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I hereby authorize Virginia iSpine Physicians, P.C. to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment or operations, which may pertain to my care. I hereby authorize payment directly to Virginia iSpine Physicians, P.C. of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with contractual terms and participatory agreements. Further, I acknowledge that I am indebted for past due charges, and I understand that I am financially responsible for those charges also. Should this account become delinquent, I agree to pay a collection fee not to exceed 33 1/3% of the balance then outstanding in addition to any court costs and/or including attorney fees.

MEDICARE PATIENTS: I authorize Virginia iSpine Physicians, P.C. to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Virginia I-Spine Physicians, P.C.

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia (whenever any health care provider or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented for testing for infection with human immunodeficiency virus. If there is an exposure and the patient's test is positive the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered. I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature _____ Date: _____

Financial Policy

IDENTIFICATION REQUIREMENTS

This practice is committed to safeguarding your identity. Federal regulations require verification of your identity at each visit to verify the identity of anyone presenting medical insurance identification. To satisfy the Federal requirements, **your driver's license will be scanned into your electronic file.** This allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent your being seen by our physicians.

ASSIGNMENT OF BENEFITS

The patient understands that payment of authorized Medicare or applicable private insurance benefits will be paid directly to Virginia iSpine Physicians, PC for services provided under their care. If insurance payments are sent to the patient directly, the patient is responsible for forwarding payment to our office with a copy of the explanation of benefits (EOB) received.

HEALTH INSURANCE ELIGIBILITY, POLICY UPDATES & NEW INSURANCES

It is the patient's responsibility to keep Virginia iSpine Physicians, PC updated with correct insurance information. If the insurance company the patient designates is incorrect, the patient will be responsible for payment of the visit. In the patient's agreement with their insurance plan, the patient is responsible for any and all co-payments, deductibles and coinsurances. It is the patient's responsibility to understand his/her benefit plan. All prior balances must be paid prior to your visit.

It is the patient's responsibility to respond to any and all requests from the insurance company for further information and/or patient demographics on their account. Failure to do so in a timely fashion may result in a claim denial and will result in the patient being responsible for any payments due to ViSP in full.

We **DO NOT** participate with all insurances. If we do not accept your insurance and you wish to be seen at our office, you may elect to pay for services in accordance with the FINANCIAL RESPONSIBILITY listed below. It is important to note that any monies paid on your self pay account will not be applied to your insurance deductible.

REFERRALS and AUTHORIZATIONS

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to reschedule. PLEASE NOTE: When calling your insurance company to find out if a pre-authorization is required for your visit, you will want to tell them you are seeking care at Virginia iSpine Physicians, PC.

BILLING INFORMATION

You may receive additional patient care services as part of your treatment at Virginia iSpine Physicians PC such as anesthesia, radiology, pathology, laboratory or other services. These services are a vital part of your care. There may be additional charges for these services and you may receive a bill from those specific partnering providers. In addition, you may receive inpatient or outpatient hospital care if and when services are rendered in a facility or at the hospital.

ABN (Advanced Beneficiary Notice)

The Federal Medicare program, administered through the Center for Medicare and Medicaid Services (CMS), and some private insurance companies, do not cover some services they consider medically unnecessary. You will be responsible for all fees related to these services. Your signature will be required on the ABN prior to receiving any potentially uncovered services. Supplemental or secondary insurances to Medicare will not cover services denied by Medicare. We recommend checking with your insurance carrier prior to treatment if you are concerned about these issues.

MISSED & CANCELLED APPOINTMENTS

The office is open 7:30am to 5:30pm, Monday through Friday. We require at least 24 business hours' notice if you must cancel an appointment. Failure to do so will result in a cancellation/ no show fee of $25.00 for office visits, $100.00 for EMG appointments or $100.00 for procedure visits. If you miss three appointments without providing the required 24 hours' notice for cancellation, we may exercise the right to discharge you from the practice.

COLLECTION OF CO-PAYS AND DEDUCTIBLES AND OTHER BALANCES

You are expected to pay your co-payment, any co-insurance, deductible amounts, and any outstanding balances in full at the time of service. If you are insured with a high deductible insurance plan and have not met your deductible, we will collect the estimated contracted rate for services rendered at the time of service. If you are unable to pay the full amount due prior to your next appointment, please request to speak with our billing manager to create an acceptable payment arrangement to satisfy your balance before your next visit. We do not accept payment plans.

RETURNED CHECKS

We do not accept checks as form of payment in the office. If you mail in a payment on services rendered in the form of a check to our billing department and the check is returned, you will be assessed a return check fee of $35.00 and will need to resubmit your original payment by either cash or credit card. If this occurs, mailed check payments will no longer be accepted for any future account balances.

FINANCIAL RESPONSIBILITY

I understand that Virginia iSpine Physicians, PC, as a courtesy, will file my insurance claims with insurance companies that the Practice participates with; however, I am ultimately responsible for the full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Virginia iSpine Physicians, PC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33 1/3%) of the total unpaid balance due. I understand and agree that should Virginia iSpine Physicians, PC be awarded judgement relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half (1 ½%) per month, eighteen (18%) per annum, beginning on the date of the judgment.

All patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits. Your remittance is due within 10 business days of your receipt of your bill. If there is a balance on your account and previous arrangements have not been made with our billing department, any account balance outstanding longer than 90 days will be forwarded to a collection's agency. Any patient account balance over 90 days past due, that does not have a financial payment contract or credit card on file, will be turned over to an outside collection agency. ***This also includes any patient account balances that have defaulted from their financial payment contract.***

CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I authorize Virginia iSpine Physicians, PC to release necessary medical information to my insurance company, its agents or any third-party payer in order for payable benefits for these services to be determined.

If you would like to request copies of your medical record, there will be an administrative Search Fee of $20.00. Pages 1–50 $0.50 per page, pages 51+ $0.25 per pages under Virginia Consent for Release of Medical Records. A separate CONSENT FOR THE RELEASE OF MEDICAL RECORDS form must be completed before your request can be honored.

OVERPAYMENTS/REFUNDS

Once **ALL** insurance and patient payments for all dates of service completed have been received and it is deemed the carrier and/or patient have made an overpayment, Virginia iSpine Physicians, P.C. will refund the overpayment to the appropriate party, in a prompt fashion.

I have read and I understand Virginia iSpine Physician PC's financial policies and understand that I am bound by the above terms. I accept responsibility for the payment of any fees associated with my care.

I acknowledge that Virginia iSpine Physicians, PC will scan this document and destroy the original, and agree that the scanned document is the same as the original.

_____ _____

Signature of Patient or Responsible Party ***Date***

_____ _____

Printed Name of Signature ***Relationship to Patient***

Patient Portal Authorization Form

Patient Name: _____

Responsible Party Name (if Patient is a Minor):

_____

Email Address / Account Holder (please print clearly):

_____

(Please supply the personal email address of the person who will be using the PATIENT PORTAL)

Purpose of this Form:
The PATIENT PORTAL offers patients of **Virginia iSpine Physicians, P.C.** a secure way to view parts of your electronic health record and communicate with our staff. Secure messaging is a valuable communication tool for our practice, but it has certain limitations and guidelines. Please read this form thoroughly before signing.

How the PATIENT PORTAL Works:
A secure WEB PORTAL is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those for whom you are legally responsible. Via the PATIENT PORTAL you will be able to:

- ✓ Use the message function to communicate with our staff
- ✓ Schedule, confirm, cancel or reschedule an appointment
- ✓ Communicate about billing questions and pay your bill online
- ✓ Request a medication refill
- ✓ View health summary information in your electronic chart and send staff requests to update information
- ✓ Print or save an electronic copy of the health summary using the continuity of care record (CCR) format

How to Participate in the PATIENT PORTAL:
Once this form is agreed to and signed, you will receive a link to the patient portal via your personal email account. Check your spam and junk folders if you do not find our email confirmation. You will need to click this link to set up your password and security question. Once this is complete, you will be able to access the patient portal via our website at www.vaispine.com . You will want to accept our website as Trusted Site.

Protecting Your Private Health Information and Risks:
This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you MUST inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer.

Conditions of Participating in the PATIENT PORTAL:
We understand the importance of privacy with regard to your health care, and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service and we may suspend or terminate it at any time for any reason. As a user of the patient portal and by signing this form you agree to:

1. Not transmit any electronic information that violates the rights or privacy of any party.
2. Use the WEB PORTAL in any way that would violate local, state or federal laws.
3. Not transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.
4. Intentionally distribute viruses code or take any other action that could compromise the security of our computer system.

Patient / Guardian Acknowledgement:

Signature: _____ Date: _____

Please send or fax back to the office at:

Virginia iSpine Physicians, P.C.
12874 Patterson Ave, Suite A
Richmond, VA 23238
Fax: (804) 327-1677

HIPAA Authorization to release information

Patient Rights:

- I have the right to revoke this authorization any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

By signing this form, you only give your consent to discuss your medical and billing information with the family members indicated below.

1. Name: _____ DOB: _____Relation to Patient: _____

2. Name: _____ DOB: _____Relation to Patient: _____

3. Name: _____ DOB: _____Relation to Patient: _____

Authorization to leave messages with Household Members / Cell Phone / Answering Machine.

Occasionally it is necessary for the staff of Virginia iSpine Physicians to leave messages for our patients. The purpose of these messages varies and may include reminders to patients of their upcoming appointments or other messages to return our calls. At no time will a representative of Virginia iSpine Physicians discuss your medical condition without your consent.

By signing this form, you give consent for VISP to leave messages with members of your household, your personal cell phone, or answering machine. **Please check all that apply:**

____ I authorize VISP to leave a detailed message on my home or cell number regarding appointments.

____ I authorize VISP to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize VISP to leave a message with anyone who answers the phone.

____ Messages may only be left with _____

Please Note: There is a separate form to fill out for Medical Record Request.

Signing below means that you have received and understand this notice.

Patient Name: _____DOB: _____ DATE: _____

Patient Signature: _____

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL YOU REVOKE IT IN WRITING.

Privacy Practices Acknowledgement

Please Note: Virginia iSpine Physicians, PC has two operating locations. When transporting PHI between locations all health care employees will take reasonable measures to ensure the confidentiality of patient's health information.

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____Birthdate _____

Signature _____

Date _____

Copy of our privacy practices can be provided to you via email, or in office upon request

Authorization to Obtain Prior Imaging Records

I hereby authorize **Virginia iSpine Physicians**, its representatives, and affiliated staff to request and obtain copies of my prior imaging studies and associated reports from the following facilities, for the purpose of continuity of care and review prior to my upcoming appointment. **We have access to Bon Secours, HCA, and VCU records.** If done at another facility, please bring a copy of the imaging with you.

Facility Name	Approximate Date of Imaging

Type of Information to be Released:
☑ Imaging Reports
☑ Imaging Files (e.g., X-rays, MRIs, CTs, etc.)

Purpose of Disclosure:
✓ Continuity of Care
✓ Pre-visit Review and Evaluation
✓ Coordination of Services

Patient Rights:

- I understand that I may revoke this authorization at any time by providing written notice.
- I understand that my treatment will not be conditioned upon the signing of this authorization.
- I understand that once the records are released, they may no longer be protected by HIPAA and could be redisclosed by the recipient.

Signing below means that you have received and understand this notice.

Patient Name: _____DOB: _____ DATE: _____

Patient Signature: _____

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL YOU REVOKE IT IN WRITING.

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PLEASE COMPLETE THIS ENTIRE FORM

Name: _____Date of Birth: _____/_____/_____

How were you referred to Virginia iSpine Physicians?

☐ Physician: _____ ☐ Relative ☐ Friend

☐ TV Ad: Channel-_____ ☐ Other – _____

Tell us why you are here today (please check the box for your primary concern for today's visit)

☐ Lower Back Pain (Axial Lumbosacral pain) ☐ Neck Pain (Axial Neck Pain)

☐ Mid Back pain (Axial Thoracic Pain) ☐ Shoulder/Arm Pain (Cervical Radic Pain)

☐ Hip and Leg Pain (L-S Radic Pain) ☐ Other: _____

Are you allergic to any of the following? (Describe type of reaction)

☐ **Check box if No Allergies**

			REACTION
a. Shellfish	☐ Yes	☐ No	_____
b. Contrast Dye	☐ Yes	☐ No	_____
c. Local anesthetic	☐ Yes	☐ No	_____
d. Medications	☐ Yes	☐ No	_____

If 'Yes,' indicate which medications: _____

What Medications are you <u>CURRENTLY</u> taking? (attach a separate piece of paper if needed)

☐ **Check box if NO MEDICATIONS**

Medication Name	Dose (#mg)	Times Taken Per Day

What Medications did you <u>PREVIOUSLY</u> take for your pain?

☐ **Check box if NO MEDICATIONS**

Medication Name	Dose (#mg)	Times Taken Per Day

Is your pain?

☐ Electrical ☐ Stabbing ☐ Dull ☐ Achy ☐ Numbness

Is your injury/condition work related? ☐ Yes W/C case number: _____ No ☐

How long have you had this pain (enter a number)? ____ Days ____ Weeks ____ Months ____ years

What seemed to <u>cause</u> your current pain condition:

☐ Unknown ☐ Lifting ☐ Athletic Activity ☐ A Fall

☐ Auto Accident: date ___/___/___ ☐ Other Trauma

<u>What activities increase and decrease your pain</u>:

INCREASES PAIN ☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Nothing**

DECREASESPAIN ☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Nothing**

Please indicate if you have received any of the following treatments for your pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)		
Treatment	**Approximate Month & Year**	**Treatment**
Surgery		
Physical Therapy ***(please provide office location)***		
Chiropractic Treatment		
Trigger Point Injections		

CONTINUED: **Treatment**	**Approximate Month & Year**	**Type of Treatment**	**Who performed this procedure?**
Injections Guided by X-Ray			
❑ Epidural Steroid Injection			
❑ Facet Joint Injection			
❑ Sacroiliac (SI) Joint Injection			
❑ Hip Joint Injection			
❑ Other			

Have you had any diagnostic imaging such as (MRI, CT, X-Ray,) within the past 6 months,
If so, when? _____ where? _____

Have you had any diagnostic testing such as DEXA (bone density or bone scan) done in the past?

If so, when? _____ where? _____

Please check (√) any of the following symptoms or problems that you have experienced during the <u>last six (6) months</u>

CONSTITUTIONAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
❑ Weight gain	❑ Chest pain / pressure/ tightness	❑ Persistent/recurring stomach pain
❑ Weight loss	❑ Palpitations	❑ Loss of bowel control
❑ Marked fatigue	❑ Rapid heart rate	❑ Diarrhea
❑ Fever	❑ Low blood pressure	❑ Constipation
❑ Sweats	❑ High blood pressure	❑ Blood in stool
❑ Excessive thirst	❑ Shortness of breath	❑ Heartburn or indigestion
❑ Heat/Cold intolerance	❑ Poor circulation	❑ Nausea/vomiting
❑ Depression or other emotional changes	**Cardiologist's Name:** _____	❑ Yellow jaundice **GI Doctor's Name:** _____
MUSCULOSKELETAL	**NEUROLOGICAL**	**RESPIRATORY**
❑ Joint pain	❑ Headaches	❑ Persistent cough
❑ Joint stiffness	❑ Blackouts/Fainting	❑ Coughing up blood
❑ Joint redness or swelling	❑ Seizures	❑ Wheezing
❑ Weakness	❑ Weakness	
❑ Cramps	❑ Memory loss	

EARS, NOSE & THROAT	SKIN	EYES
❑ Loss of hearing	❑ Frequent bruising	❑ Blurred vision
❑ Vertigo/Dizziness	❑ Rash	❑ Double vision
❑ Ringing in ears	❑ Nail or hair changes	❑ Eye pain
❑ Sinus problems	❑ Hives	
	❑ Sores that don't heal	
GENITOURINARY	**MEN ONLY**	**WOMEN ONLY**
❑ Blood in urine	❑ Breast lump	❑ Extreme menstrual pain
❑ Painful urination	❑ Penis discharge	❑ Vaginal discharge
❑ Urgency to urinate	❑ Sore on penis	❑ Painful intercourse
❑ Loss of bladder control	❑ Lump on testicle	❑ Breast pain
❑ Frequent urination	❑ Other: _____	❑ Nipple discharge
❑ Difficulty urinating		❑ Breast lump - if yes, date of last mammogram _____

Medical History - Check (√) any of the following conditions or problems that you have faced at <u>any time in your life.</u>

o AIDS	o Emphysema	o Mononucleosis	o Tuberculosis
o Alcoholism	o Glaucoma	o Multiple Sclerosis	o Typhoid Fever
o Anorexia/Bulimia	o Heart Disease	o Mumps	o Vascular Disease
o Arthritis	o Hepatitis	o Pacemaker Implant	o Other (list)
o Asthma/COPD	Type: _____	o Pneumonia	_____
o Bleeding Disorder	o Hernia	o Polio	_____
o Cataracts	o HIV Positive	o Prostate Problems	_____
o Cancer	o Hypertension	o Psychiatric Conditions	_____
Type: _____	o Kidney Disease	o Rheumatic Fever	
o Chicken pox	o Liver Disease	o Stomach Ulcer	
o Diabetes - Type: _____	o Measles	o Stroke	
o Drug Dependency	o Migraine Headaches	o Thyroid Condition	

Surgical History – Please list any previous surgeries and their respective dates
☐ **Check box if no previous surgical history**

Approx Date	Surgery

Family History – Please (√) any conditions experienced by your parents, children, or siblings:

☐ Check box if no family history ☐ Unknown family history

	Parents	Siblings	Children
High Blood Pressure			
Diabetes			
Cancer			
Heart Disease			
Stroke			
Back/Neck Pain			
Rheumatoid Arthritis			

Social / Vocational / Work History

Do you smoke cigarettes? ☐ Yes ☐ No

If 'No,' did you ever smoke? ☐ Yes ☐ No

If 'Yes,' indicate how much you smoke/smoked per day by checking one of the following:

☐ Less than ¼ pack per day ☐ About ¾ pack per day (15 cigarettes)

☐ About ¼ pack per day (5 cigarettes) ☐ About 1 pack per day (20 cigarettes)

☐ About ½ pack per day (10 cigarettes) ☐ More than 1 pack per day

Do you have a history of alcohol or drug abuse? ☐ **Yes** ☐ **No**

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status ☐ Unemployed ☐ Employed ___ Full Time ___ Part Time

Employer Name: _____

If unemployed right now, indicate the last date worked: ____/____/____

If out of work, what was your reason for leaving? ☐ Due to pain problem ☐ Not due to pain

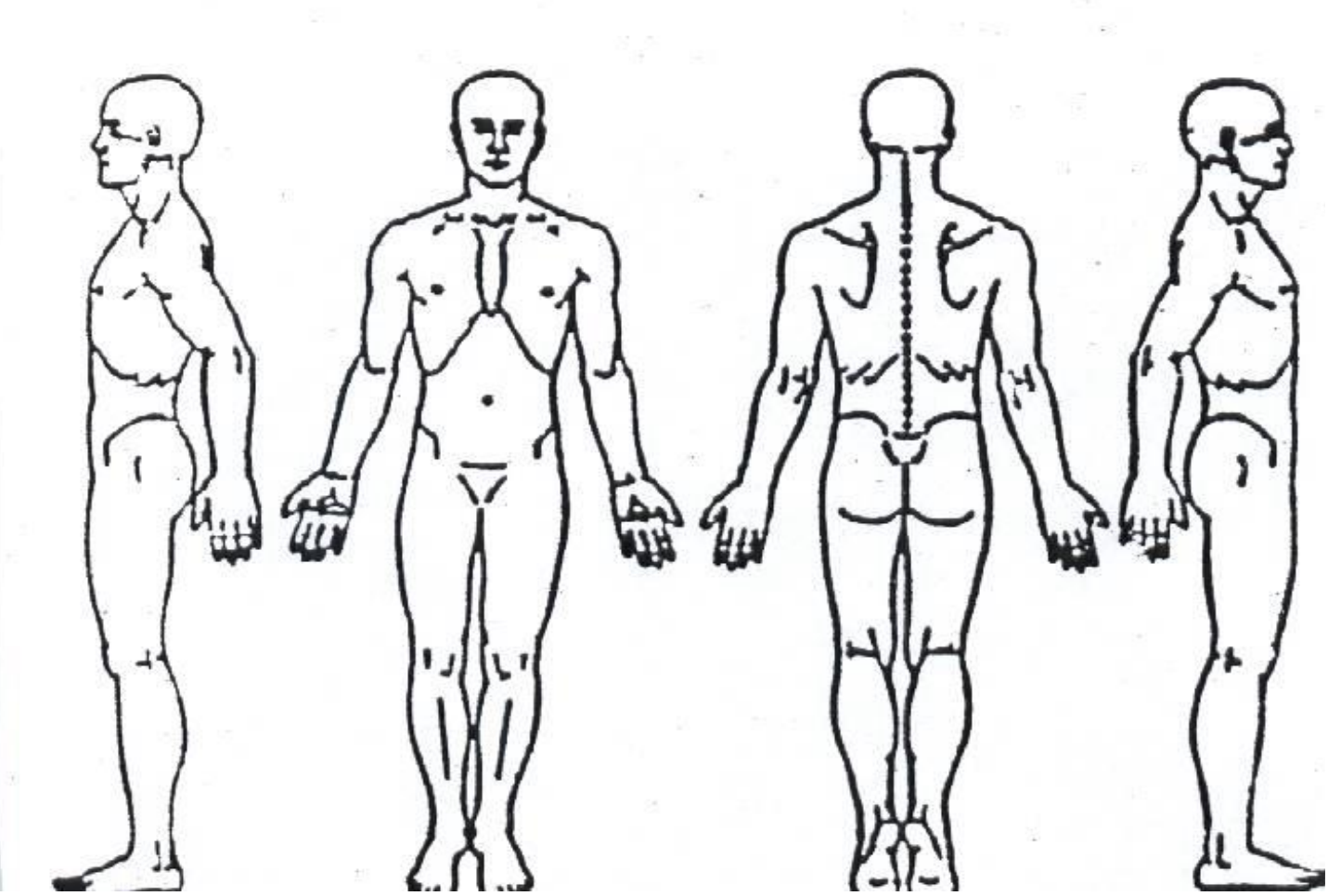
Patient Signature: _____ **Date _____**

PAIN DIAGRAM

Name: _____ Date: _____

Draw the location of your pain on the body outlines & mark how severe it is on the pain line at the bottom of the page. Use a red pen if available.

Aching	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	⇒⇒⇒	000000	*****	/////	xxxx
^^^^	⇒⇒⇒	000000	*****	/////	xxxx



PAIN LINE Draw a perpendicular line or arrow to indicate your usual level of pain.

no pain **severe pain**

PI:	Patient Initials: ___ ____ ___ *First Middle Last*	Patient Number
Oswestry Disability Questionnaire	Date of Assessment: ____/____/____ *Month/ Day/ Year*	

VISIT TYPE: □ Baseline □ _____ □ _____ □ _____ □ _____ □ _____

This questionnaire has been designed to give us information as to how your back/leg/hip/knee pain has affected your ability to manage in everyday life. Please answer every question by checking **one box in each section** that best describes your condition today. We realize you may feel that two or more statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Section 1- Pain Intensity
□ I have no pain at the moment.
□ The pain is very mild at the moment.
□ The pain is moderate at the moment.
□ The pain is fairly severe at the moment.
□ The pain is very severe at the moment.
□ The pain is the worst imaginable at the moment.

Section 2- Personal Care (e.g., Washing, Dressing)
□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed, wash with difficulty, and stay in bed.

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

Section 4- Walking
□ Pain does not prevent me walking any distance.
□ Pain prevents me walking more than 1 mile.
□ Pain prevents me walking more than a quarter of a mile.
□ Pain prevents me walking more than 100 yards.
□ I can only walk using a cane or crutches.
□ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting
□ I can sit in any chair as long as I like.
□ I can only sit in my favorite chair as long as I like.
□ Pain prevents me sitting more than 1 hour.
□ Pain prevents me sitting more than half an hour.
□ Pain prevents me sitting more than 10 minutes.
□ Pain prevents me from sitting at all.

Section 6-Standing
□ I can stand as long as I like without extra pain.
□ I can only stand as long as I like but it gives me extra pain.
□ Pain prevents me standing more than 1 hour.
□ Pain prevents me standing more than half an hour.
□ Pain prevents me standing more than 10 minutes.
□ Pain prevents me from standing at all.

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

Section 8- Sex Life (if applicable)
□ My sex life is normal and causes no extra pain.
□ My sex life is normal but causes some extra pain.
□ My sex life is nearly normal but is very painful.
□ My sex life is severely restricted by pain.
□ My sex life is nearly absent because of pain.
□ Pain prevents me any sex life at all.

Section 9- Social Life
□ My social life is normal and causes me no extra pain.
□ My social life is normal but increased the degree of pain.
□ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g sport, etc.
□ Pain has restricted my social life and I do not go out as often.
□ Pain has restricted my social life to my home.
□ I have no social life because of pain.

Section 10- Traveling
□ I can travel anywhere without pain.
□ I can travel anywhere, but it gives me extra pain.
□ Pain is bad, but I manage journeys over 2 hours.
□ Pain restricts me to journeys of less than 1 hours.
□ Pain restricts me to short necessary journeys under 30 minutes.
□ Pain prevents me from traveling except to receive treatment.

Lumbar Functional Status FOTO Patient Intake Form

(©Focus on Therapeutic Outcomes, Inc.)

Patient Name: _____ DOB: _____ Date: _____

The following assessment will ask you about difficulties you may have with certain activities. It is an important part of your evaluation. It will help us understand how your condition is affecting your activities, and develop treatment goals with you.

Please answer the questions with respect to the problem for which we are seeing you. Respond based on how you have been over the past few days. If you do not do or have done this activity, please make your best guess as to which response is more accurate.

Activities	Unable to perform activity	Extreme Difficulty	Quite a Bit of Difficulty	Moderate Difficulty	A little Bit of Difficulty	No Difficulty
Any of your usual work, housework, or school activities	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
Your usual hobbies, recreational, or sporting activities	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
Performing heavy activities around your home	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
Bending or stooping	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6
Lifting a box of groceries from the floor	□ 1	□ 2	□ 3	□ 4	□ 5	□ 6

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	□ 1	□ 2	□ 3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	□ 1	□ 2	□ 3
Lifting or carrying groceries	□ 1	□ 2	□ 3
Attending social or cultural events	□ 1	□ 2	□ 3
Getting in and out of your chair	□ 1	□ 2	□ 3

Neck Disability Index

The questionaire is designed to help us better understand how your neck/shoulder/arm pain affects your ability to manage everyday life activities. Please mark in each section the **one statement** that best applies.

Section 1 – Pain Intensity

_ I have no pain at the moment.
_ The pain is very mild at the moment.
_ The pain is moderate at the moment.
_ The pain is fairly severe at the moment.
_ The pain is very severe at the moment.
_ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

_ I can look after myself normally but it is very painful.
_ It is painful to look after myself and I am slow and careful.
_ I need some help but manage most of my personal care.
_ I need help every day in most aspects of my personal care.
_ I need help every day in most aspects of self-care.
_ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

_ I can lift heavy weights without extra pain.
_ I can lift heavy weights but it gives me extra pain.
_ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
_ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
_ I can lift only very light weights.
_ I cannot lift or carry anything at all.

Section 4 – Work

_ I can do as much work as I want.
_ I can do my usual work, but no more.
_ I can do most of my usual work, but no more.
_ I can't do my usual work.
_ I can hardly do any work at all.
_ I can't do any work at all.

Section 5 – Headaches

_ I have no headaches at all.
_ I have slight headaches that come infrequently.
_ I have moderate headaches that come infrequently.
_ I have moderate headaches that come frequently.
_ I have severe headaches that come frequently.
_ I have a headache almost all the time.

Section 6 – Concentration

_ I can concentrate fully when I want to with no difficulty.
_ I can concentrate fully when I want to with slight difficulty.
_ I have a fair degree of difficulty in concentrating when I want to.
_ I have a lot of difficulty in concentrating when I want to.
_ I have a great deal of difficulty in concentrating when I want to.
_ I cannot concentrate at all.

Section 7 – Sleeping

_ I have no trouble sleeping
_ My sleep is slightly disturbed for less than an hour.
_ My sleep is mildly disturbed for 1-2 hours.
_ My sleep is moderately disturbed for 2-3 hours.
_ My sleep is greatly disturbed for up to 3-5 hours.
_ My sleep is completely disturbed for up to 5-7 hours

Section 8 – Driving

_I can drive my car without neck pain.
_I can drive as long as I want with slight neck pain.
_I can drive as long as I want with moderate neck pain.
_I can't drive as long as I want because of moderate neck pain.
_I can hardly drive at all because of severe neck pain.
_I can't drive my car at all because of neck pain.

Section 9 – Reading

_ I can read as much as I want with no neck pain.
_ I can read as much as I want with slight neck pain.
_ I can read as much as I want with moderate neck pain.
_ I can't read as much as I want because of moderate neck pain.
_I can't read as much as I want because of severe neck pain.
_I can't read at all.

Section 10 – Recreation

_ I have no neck pain during all recreational activities.
_ I have some neck pain with all recreational activities.
_ I have some neck pain with a few recreational activities.
_ I have neck pain with most recreational activities.
_ I can do hardly do recreational activities due to neck pain.
_ I can't do any recreational activities due to neck pain.

Patient Name: _____ *Date*: _____ *Score:* _____ [50] *Benchmark -5* =: _____