COLUMBUS ORTHOPAEDIC
CLINIC & OUTPATIENT CENTER

# Dr. Edwards New Patient Paperwork

Please fill out these forms completely

Date of Appointment _____

Complete the enclosed packet and bring it to the appointment along with all X Rays, MRI disc and reports.

Please bring your insurance cards and picture ID

Providing high-quality care and patient satisfaction is important to us at Columbus Orthopaedic Clinic and Outpatient Center. Please understand that each patient will receive individualized care. Because of this variability, your appointment may not start at your designated time. We appreciate your cooperation.

Email Address:_____

Please list medical doctors and reasons used:

PCP: _____

Cardiologist: _____

Pulmonologist:_____

Nephrologist:_____

Endocrinologist:_____

Hematologist: _____

Oncologist: _____

Other:_____

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**Please fill out these forms completely!**

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated. Thank you for helping us to know you better!

Date:_____

Patient Name:_____
(please print)

Gender: Male Female

Date of Birth:_____
(month/day/year)

Current Age:_____

## FACTORS OF COMPLAINT

**What do you want to happen as a result of this visit?**

_____

_____

_____

_____

_____

_____

**How and when did your problem begin?**
(Please mark each answer that applies to your neck/back pain.)

- ☐ I don't know how it began.
- ☐ It comes and goes.
- I've had it a long time. (_____years)
- Injury (date of injury_____) On the job? ☐ yes ☐ no
- Please explain how the injury happened.

_____

Are you currently in litigation with regards to your back pain?
☐ yes ☐ no

Have you been laid off from your job? ☐ yes ☐ no ☐ N/A

**Do you have any of the following problems?**
(Please check your answer.)

Is your pain worse at night? ☐ yes ☐ no

Does your pain awaken you from sleep? ☐ yes ☐ no

Does coughing affect your pain? ☐ yes ☐ no

Do your legs tire/hurt if you walk too far? ☐ yes ☐ no

If YES, how far can you walk?
☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks

Is this relieved by resting your legs? ☐ yes ☐ no

Is this relieved by bending forward? ☐ yes ☐ no

**Bladder Control (urine):**

- ☐ No problem
- ☐ Can't empty bladder
- ☐ Loss of urine (accidents)

**Bowel Control:**

- ☐ No problem
- ☐ Constipation
- ☐ Loss of control (accidents)

**How does each of the following affect your pain? (check your answer)**

| | | | | |
|---|---|---|---|---|
| Sitting | ☐ Better | ☐ Worse | ☐ No change | |
| Standing | ☐ Better | ☐ Worse | ☐ No change | |
| Walking | ☐ Better | ☐ Worse | ☐ No change | |
| Lying down | ☐ Better | ☐ Worse | ☐ No change | |
| Rising from chair | ☐ Better | ☐ Worse | ☐ No change | |
| Physical activity | ☐ Better | ☐ Worse | ☐ No change | |
| Heat | ☐ Better | ☐ Worse | ☐ No change | ☐ Don't know |
| Cold | ☐ Better | ☐ Worse | ☐ No change | ☐ Don't know |

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## PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If **YES**, did it make your condition better or worse?

**Have you had:**

Chiropractic care ○better ○worse

Physical therapy ○better ○worse

Injections ○better ○worse

Psychological consultation ○better ○worse

Other_____ ○better ○worse

**For your current back/neck pain, please mark the boxes for the time-frame that any tests were done.**

X-rays ○<6 to 12 mo • When/Where _____

MRI scan ○<6 to 12 mo • When/Where _____

CT scan ○<6 to 12 mo • When/Where _____

Myelogram ○<6 to 12 mo • When/Where _____

Discogram ○<6 to 12 mo • When/Where _____

EMG/NCV ○<6 to 12 mo • When/Where _____

**Have you ever had surgery on your back or neck?**

○yes ○no

If YES, complete the following:

**1. Type of surgery**_____

Date_____

Surgeon_____

Did it make your pain ○better or ○worse?

**2. Type of surgery**_____

Date_____

Surgeon_____

Did it make your pain ○better or ○worse?

**2. Type of surgery**_____

Date_____

Surgeon_____

Did it make your pain ○better or ○worse?

## GENERAL MEDICAL HISTORY

**Check all the conditions below that you have currently or have had in the past. If NONE check ☐**

○Heart attack
○Heart murmur
○Angina
○High blood pressure
○Stroke
○Varicose veins
○Stomach ulcer
○Duodenal problems
○Anemia (low blood count)
○COPD

○ Colon problems
○ Diabetes
○ Hepatitis
○ Cirrhosis
○ Kidney stones
○ Kidney infection
○ Degenerative arthritis
○ Rheumatoid arthritis
○ Bleeding tendency
○ Sleep Apnea

○ Gout
○ Anxiety
○ Depression
○ Emphysema
○ Tuberculosis
○ Chronic bronchitis
○ Frequent pneumonia
○ Asthma
○ Sexual difficulty
○ Enlarged prostate

○ Menstrual problems
○ Cancer: type_____
○ Osteoporosis

**Have you used :**

○ Immuno-suppression?
○ Corticosteroids
○ Pacemaker or internal defibrillator

Other_____

**List any major surgery you have had, other than on your back or neck.**

| Type of surgery | Year |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

**Are you allergic to any medications, foods or environmental substances?**

○yes ○no If YES, list the medications.

_____

_____

_____

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## FAMILY MEDICAL HISTORY

| I do not know the medical history of my biological parents or other family members. (Go on to next section.) | Mother:<br>◯ Alive age:_____<br>◯ Deceased at age:_____<br>due to _____ | Father:<br>◯ Alive age:_____<br>◯ Deceased at age:_____<br>due to _____ | Number of living brothers/ sisters _____<br>Number of deceased brothers/sisters _____ |
|---|---|---|---|

**Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:**
**Check all that apply:**

◯ Stroke
◯ Diabetes
◯ Lung disease
◯ High Blood Pressure
◯ Heart trouble
◯ Back problems
◯ Cancer
◯ Osteoporosis
◯ Scoliosis
◯ Kyphosis
◯ Arthritis
◯ None of these
◯ Don't know
◯ Other

## SOCIAL HISTORY

**Marital Status**
◯ Married
◯ Separated
◯ Divorced
◯ Single
◯ Widow/widower

**Education**
Check the highest level completed:
◯ Grammar school
◯ High school
◯ College
◯ Post-graduate

**Smoking**
◯ Current Every Day Smoker
◯ Current Some Day Smoker
◯ Former Smoker
◯ Never Smoker
◯ Smoker – Current Status Unknown
◯ Unknown If Ever Smoked
Patient Smokes: Every Day Some Days
Year Started _____
◯ Cigarettes Amt: _____ packs/day
◯ Cigars Amt: _____ # per week
◯ Smokeless/Chewing Amt: _____ per Day
◯ Has had tobacco cessation counseling

**Alcohol**
Do you drink:
Beer: ◯ yes ◯ no Amt: _____ per day
Wine: ◯ yes ◯ no Amt: _____ glasses/day
Hard" drinks: ◯ yes ◯ no Amt: _____ day

**Frequency of drinking:**
◯ never
◯ rarely Amt: _____ drinks/day
◯ socially
◯ daily

Do you have a history of heavy drinking?
◯ yes ◯ no

**Effect of your back/neck pain on your lifestyle.**

| | |
|---|---|
| I describe my home setting as supportive of me during this time. | ◯ yes ◯ no |
| I describe my work setting as supportive of me during this time. | ◯ yes ◯ no |
| My pain has affected my interaction with my family and friends. | ◯ yes ◯ no |
| The changes in my lifestyle due to my problem have been difficult for me | ◯ yes ◯ no |

**What is your ability to enjoy life?**
◯ Excellent
◯ Very good
◯ Good
◯ Fair
◯ Poor

**Please indicate your current work status.**
◯ Working full time
◯ Working part time
◯ Seeking employment
◯ Not working by choice (retired, homemaker, student, etc.)
◯ Physically unable to work due to back/neck problem
◯ Physically unable to work not due to back/neck problem

**Before having back or neck pain, did you normally work:**
◯ full time ◯ part time ◯ neither
What is your usual occupation?
_____
Do you like your work situation?
◯ yes ◯ no ◯ N/A

**Has your pain affected your ability to do your job or any other daily activities?** ◯ yes ◯ no
If YES, please explain_____

**Is there anything we have failed to ask that you believe is important for us to know?** ◯ yes ◯ no
If **YES**, please explain: _____

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## REVIEW OF SYSTEMS

**Do you have any of the following?**

**General:**
Recent weight loss of more than 10 pounds? ○ yes ○ no
Recent weight gain of more than 10 pounds? ○ yes ○ no
Fever?_____ ○ yes ○ no
Chills?_____ ○ yes ○ no
Night sweats? _____ ○ yes ○ no

Have you seen your primary care physician in the past year? ○ yes ○ no

**Cardiac:**
Chest pain ○ yes ○ no
Shortness of Breath ○ yes ○ no

**Respiratory:**
Wheezing ○ yes ○ no
Pneumonia ○ yes ○ no
Chronic cough ○ yes ○ no

**Gastrointestinal:**
Abdominal pain ○ yes ○ no
Nausea ○ yes ○ no
Vomiting ○ yes ○ no
Diarrhea ○ yes ○ no
Liver problems ○ yes ○ no

**Skin:**
Open sores ○ yes ○ no
New moles ○ yes ○ no
Poor healing ○ yes ○ no
Skin infection ○ yes ○ no

**Hematoligic/Oncologic:**
Easy bruising ○ yes ○ no
Blood thinning medications ○ yes ○ no
Blood transfusion ○ yes ○ no
Organ transplant ○ yes ○ no

**Bones/Joints:**
Shoulder pain ○ yes ○ no
Wrist/hand pain ○ yes ○ no
Hip pain ○ yes ○ no
Knee pain ○ yes ○ no
Lupus ○ yes ○ no
Muscle weakness ○ yes ○ no
Fibromyalgia ○ yes ○ no

**Genitourinary:**
Abnormal kidney function ○ yes ○ no
Pain with urination ○ yes ○ no
Frequent urinary infections ○ yes ○ no

**Mental Health:**
Sleep disturbances ○ yes ○ no
Feeling of hopelessness ○ yes ○ no

**Nervous System:**
Headaches ○ yes ○ no
Tremors ○ yes ○ no
Poor speech ○ yes ○ no
Changes in vision ○ yes ○ no

**Endocrine:**
Thyroid problems ○ yes ○ no

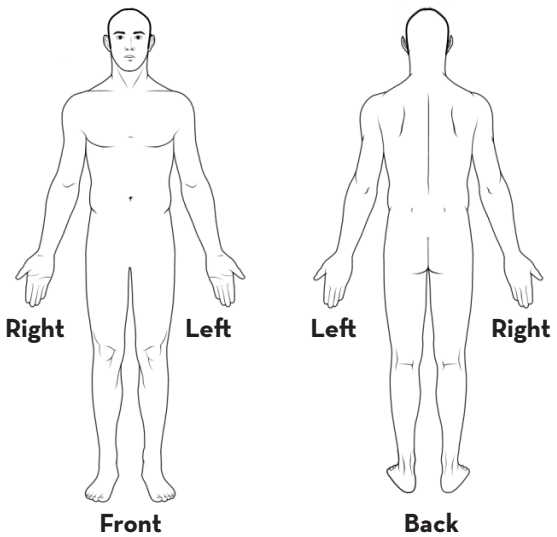
## PAIN DIAGRAM

Name:_____ Age:_____ Gender: ○ Male ○ Female Date:_____

Height:_____ Weight:_____ Pulse:_____ BP:_____ Temp:_____

Please mark the areas where you experience the following sensations:

Ache: ^^^ Numbness OOO Pins and Needles === Burning XXX Stabbing ///




### Medication Refills

_____

_____

_____

_____

_____

_____

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## PAIN SCALE

Since your last office visit are you: ○better ○worse ○the same?
How bad is your low back pain? Select on each of the lines below to indicate your current pain.

How bad is your **low back** pain?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○
No pain Worse

How bad is your **leg** pain?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○
No pain Worse

How bad is your **middle back** pain?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○
No pain Worse

How bad is your **neck** pain?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○
No pain Worse

How bad is your **arm** pain?

1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10○
No pain Worse

## BACK PAIN QUESTIONNAIRE

**If you have LOW BACK pain complete this page, if you only have neck pain, SKIP this page.**
**Please Read:** Complete this questionnaire. It is designed to give us information on how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark **one box only in each section** that most closely describes you today.

**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 (eg. 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 can 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 lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ○ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ○ I can only lift very light weights
- ○ I cannot lift or carry anything

**Section 4: Walking**
- ○ Pain does not prevent me walking any distance
- ○ Pain prevents me from walking more than 2 kilometers
- ○ Pain prevents me from walking more than 1 kilometer
- ○ Pain prevents me from walking more than 500 meters
- ○ I can only walk using a stick or crutches
- ○ I am in bed most of the time

**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 one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

**Section 6: Standing**

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for 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 any sex life at all

**Section 9: Social Life**

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- 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 two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

## NECK PAIN QUESTIONNAIRE

**If you have NECK pain complete this page, if you only have back pain, SKIP this page.**
**Please Read:** This questionnaire has been 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 choosing ONE CHOICE that most applies to you. We realize you may consider that two of the statements in any one section relate to you, but PLEASE, JUST MARK THE ONE CHOICE WHICH MOSTLY DESCRIBES YOUR PROBLEM RIGHT NOW.

**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 (eg. 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 can 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 lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

**Section 4: Reading**

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I cannot read as much as I want to because of moderate pain in my neck.
- I cannot read as much as I want to because of severe pain in my neck.
- I cannot read at all

**Section 5: Headaches**

- I have no headaches at all.
- I have slight headaches with some infrequently.
- I have moderate headaches with some infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

**Section 6: Concentration**

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

**Section 7: Work**

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

**Section 8: Driving**

- I can drive my car without any neck pain.
- I can drive my car as long as.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my back.
- I cannot drive my car at all.

**Section 9: Sleeping**

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

**Section 10: Recreation**

- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in all of my recreational activities with no neck pain at all.
- I am able to engage in most but not all of my recreational activities with because of pain in my neck.
- I am able to engage in a few of my recreational activities because of pain in my neck.
- I can hardly do any of my recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

## PATIENT QUESTIONNAIRE

Instructions: This survey asks for your views about your health. The information will help keep track of how well you are able to do your usual activities.

Please answer each question by marking one box. If you are unsure about how to answer please give the vest answer you can.

1) I general would you say your health is: Excellent Very good Good Fair Poor

2) The following items are about activities that you might do during a typical day. Does your health now limit you in these activities? If so how much: Yes limited Yes limited Not limited

3) Fill in one circle on each line

| | | | |
|---|---|---|---|
| Moderate activities, such as moving a table, pushing | A lot | A little | Not limited at all |
| A vacuum cleaner, bowling, or playing golf? | A lot | A little | Not limited at all |
| Climbing several flights of stairs? | A lot | A little | Not limited at all |

4) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
Accomplished less that you would like. Yes No
Were limited in the kind of work or other activities. Yes No

5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)
Accomplished less that you would like Yes No
Didn't do work or other activities as carefully as usual. Yes No

6) During the past 4 weeks how much did pain interfere with your normal work (indicate work outside the home and housework)?
○Not at all ○A little bit ○Moderately ○Quite a bit ○Extremely

7) These questions are about how you feel and how things have been with you during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

| | | | | | |
|---|---|---|---|---|---|
| Have you felt calm and peaceful? | ○Not at all | ○A little bit | ○Moderately | ○Quite a bit | ○Extremely |
| Do you have a lot of energy? | ○Not at all | ○A little bit | ○Moderately | ○Quite a bit | ○Extremely |
| Have you felt downhearted and blue? | ○Not at all | ○A little bit | ○Moderately | ○Quite a bit | ○Extremely |

8) During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
○All of the time ○Most of the time ○Some of the time ○A little of the time ○None of the time

| **Medication Name:** Ex. Ibuprofen | **Dose and Instructions:** 800mg Once daily | **Prescribing Physician:** Dr. John Smith |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |
| 16. | | |
| 17. | | |
| 18. | | |

*Return, medication list, new patient paperwork, and all prior imaging (disc and written report), as well as any medical records you have for your back or neck, prior to your appointment.*

Preferred Pharmacy: _____