SPINE PAIN DIAGNOSTICS ASSOCIATES

V. Singh, MD / C. Piryani, MD

Pain Questionnaire

Name: _____ DOB: _____ Age: _____

Who is your primary care physician? _____

Current Pharmacy: _____

MAIN reason for this visit: _____

_____

_____

_____

WHEN AND HOW did the pain start? _____

_____

_____

_____

For Nurse use only: Vital Signs

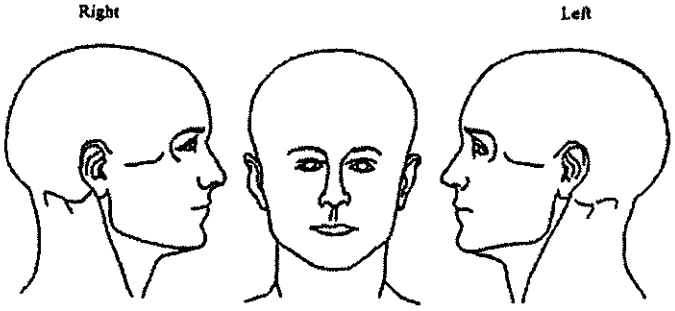
B/P: _____ HR: _____ RR: _____ T: _____ SpO2: _____

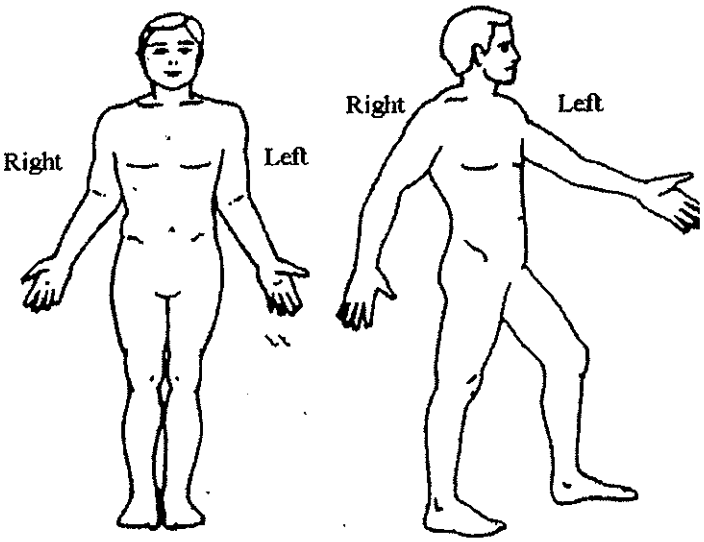
Height: _____ Weight: _____ BMI: _____

Nurse comments:

Nurse/Admitter Signature: _____ Date: _____

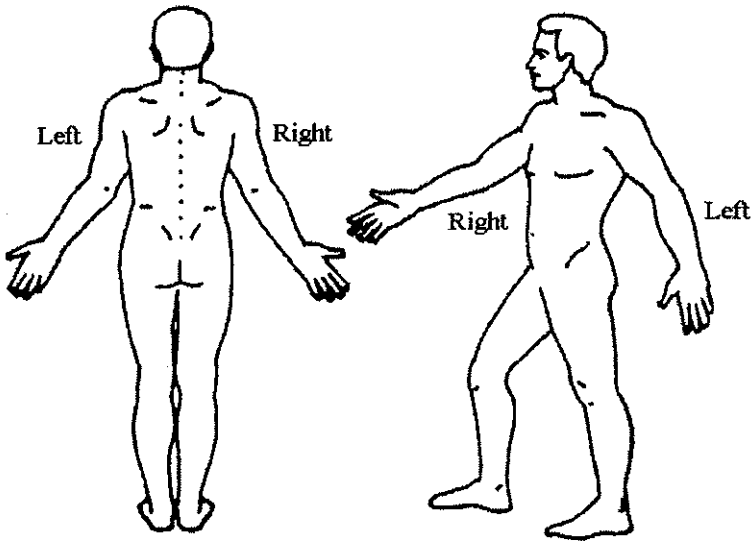
Please shade in your painful areas on the diagrams.

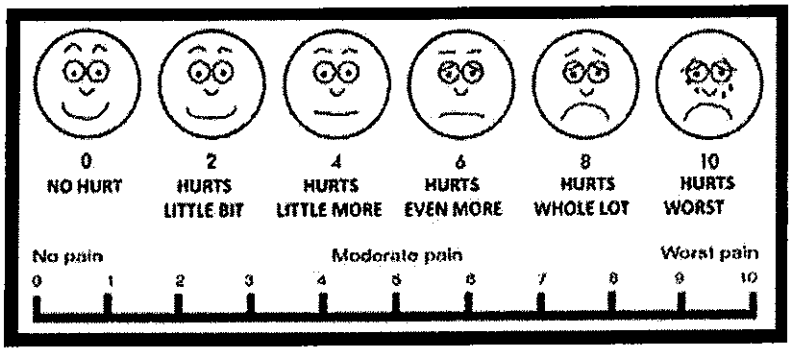




FOR NURSE USE ONLY:
PAIN DISTRIBUTION

REFERRED OR RADIATION





PAIN SCALE VAS:

Using the pain scale above (0 – 10), please give a number to the pain you experience doing the following things:

Resting pain level (sitting, lying down): _____

Daily activity pain level (while walking, standing, dressing, etc.): _____

Strenuous activity pain level: _____ What activities? _____

Pain level with medication? _____

Average /Typical pain level: _____

Acceptable pain level? _____

	Yes	No
Does your pain interrupt your sleep?		
Is your pain worse at night compared to daytime?		
Does your pain affect your daily activities?		

Is your pain: ☐ Constant ☐ Off & On ☐ Occasional ☐ With activity ☐ At rest

Briefly describe your pain:

	Yes	No
Burning Pain		
Gnawing Pain – Continuous with constant intensity worsen with movement		
Muscle Pain		
Pressing Pain		
Referred Pain – Pain sensation felt in a site other than that is actually occurring		
Stabbing Pain		
Throbbing Pain		
Other		

Aggravating or Relieving Factors

Please check which of the following activities change the nature of your pain.

	Increases Pain	No change	Decreases Pain
When you first get out of bed			
Getting up			
Sitting			
Standing			
Leaning forward			
Walking			
Climbing stairs			
Lying on your side			
Lying on your back			
Lying on your stomach			
Driving			
Coughing/Sneezing			
Stooping			
Lifting			
Bending backwards			
Turning			
Other			
Other			

☐ Pain occurs at rest or with activity (pain is not relieved by anything).

Do you experience any of the following symptoms?

	Yes	No				
Unexplained weight loss / gain						
Current infection/get infection easily						
Fracture or suspected fracture						
Numbness in genitalia/anal region						
Loss of bladder control/unable to hold			Old symptom?	How long?	New symptom?	How long?
Loss of bowel control/unable to hold			Old symptom?	How long?	New symptom?	How long?
Weakness			Where?			
Numbness			Where?			
Tingling			Where?			

Please indicate which of the following have been used to treat your *present condition*, and if it was helpful or not. Please also indicate where and when you had the treatment.

	Yes	No	Helpful	Not Helpful	Made Worse	Where/When/How Long
Surgeries (please list in spaces below):						
Medications (please list in spaces below):						
Physical Therapy						
Chiropractic						
Injection Therapy						
Other (massage, acupuncture, TENs unit, comprehensive pain management, etc.)						

Have you had recent medical or surgical opinion? Yes _____ No_____
When? _____ Where? _____
Physician Name: _____

Please list your prescription medications. Please include all medications, such as for pain, blood pressure, diabetes, eye/ear drops, inhaled medications, etc. **By giving us this information, you give permission for us to check with your pharmacy if there are questions about your current medications.**

Medication	Dose	How often/when do you take it?	Prescribing Doctor	Pharmacy

Please list non-prescription medications (Tylenol, Advil, Prilosec, Vitamins, Supplements, etc.):

Medication	Dose	Times/Day

Do you have allergies to any of the following?

Medications (please list below):	Yes	No	Symptoms
Cortisone/Steroids			
Local anesthetics (Novacaine, etc.)			
Iodine			
Latex			
Tape			
Contrast Dye			

Medical History: Please check all current or past medical conditions

Cancer:

Type:

Date of diagnosis:

Type of treatment:

Length of treatment:

Oncologist:

Clearance:

Remission: Y N Cured: Y N

Head and Face:

- ☐ Cluster headache
- ☐ Migraine headahe
- ☐ Tension or stress headache

Eyes:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration

Ears:

- ☐ Chronic or frequent ear infection
- ☐ Hearing loss

Mouth and Throat:

- ☐ Sleep Apnea

Cardiovascular:

- ☐ Aneurysm
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis (blood clots in deep veins)
- ☐ Elevated blood cholesterol
- ☐ Heart valve defect
- ☐ Hypertension
- ☐ Peripheral vascular disease
- ☐ Raynaud's disease

Respiratory:

- ☐ Asthma
- ☐ Chronic obstructive pulmonary disease/Emphysema
- ☐ Pneumonia

Gastrointestinal:

- ☐ Chronic constipation
- ☐ Cirrhosis
- ☐ Gastroesophageal reflux (GERD)
- ☐ Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Stomach ulcer

Kidney/Urinary:

- ☐ Stress incontinence
- ☐ Kidney disease
- ☐ Renal failure

Musculoskeletal:

- ☐ Ankylosing spondylitis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Chronic fatigue syndrome
- ☐ Disk disorder in back
- ☐ Disk disorder in neck
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Scoliosis

Neurologic:

- ☐ Dementia
- ☐ Neuralgia
- ☐ Paralysis
- ☐ Progressive neurologic disorder
- ☐ Restless leg syndrome
- ☐ Stroke (CVA)

Mental Health:

- ☐ Alcohol or Drug treatment
- ☐ Alcoholism
- ☐ Chronic anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Drug dependency
- ☐ IV drug abuse
- ☐ Post-traumatic stress disorder
- ☐ Sexually abused

Endocrine

- ☐ Type I diabetes
- ☐ Type II diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Hematologic and Lymphatic:

- ☐ Anemia
- ☐ Clotting disorder
- ☐ Idiopathic thrombocytopenic purpura

Immunologic:

- ☐ Autoimmune Disorders
- ☐ HIV Positive
- ☐ MRSA

Others:

Please list any other surgeries you had, including where and when you had them.

Surgery	Where	When

Have you had any of the following?

Indicate region of the body	Yes	No	Where	When
MRI				
CT scan				
Myelogram				
X-ray				
EMG				
Bone scan				
Bone Density				

Immunization

Influenza Vaccination ☐ Yes ☐ No When_____

Diagnostic and Screening Test

Stomach and Digestive System: Colonoscopy ☐ Yes ☐ No When_____

Fecal Occult Blood Testing ☐ Yes ☐ No When_____

Reproductive System (Female only) : PAP Smear ☐ Yes ☐ No When_____

Mammography ☐ Yes ☐ No When_____

Family History of Illnesses & Diseases

	Living	Deceased	Age	Back Problems	Osteoporosis	Arthritis	Diabetes	Other: Cancer, Heart Disease, Blood clots
Mother								
Father								
Children								
Siblings								

Employment

Are you currently working? ☐ Yes (☐ Part-time ☐ Full-time) ☐ No ☐ Retired

If yes, please describe occupation, including job tasks:

_____

Has pain forced you to stop working or limited your capacity at work? ☐ Yes ☐ No

Are you under any work restrictions (please list below)? ☐ Yes ☐ No

_____

How long have you been off work, or restricted at work, due to pain? _____

Is this a Workman's Comp case? ☐ Yes ☐ No

Is there litigation involved? ☐ Yes ☐ No

Personal History

What is the highest level of education you have completed? _____

Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

Do you currently smoke or use tobacco? ☐ Yes ☐ No (How much? _____ For how long? _____)

Have you ever smoked/used tobacco? ☐ Yes ☐ No (How much? _____ For how long? _____)

Do you currently smoke/use marijuana? ☐ Yes ☐ No (How much? _____ For how long? _____)

Do you drink alcohol? ☐ Yes ☐ No (How much? _____ ☐ daily ☐ weekly ☐ rarely)

Are you using illegal drugs? ☐ Yes ☐ No (which drugs: _____)

Consequences of alcohol or drug use? ☐ DUI ☐ Job loss ☐ Illness ☐ Injury ☐ Incarceration

History of prescription drug abuse? ☐ Yes ☐ No (which drugs: _____)

Do you have a living will? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

What is your dominate hand? ☐ Left ☐ Right

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Never (why? _____)

REVIEW OF SYSTEMS

Have you experienced any of the following?

Yes

CONSTITUTIONAL:
- ☐ Change in appetite
- ☐ Increased dizziness
- ☐ Excessive daytime sleepiness
- ☐ Fatigue
- ☐ Fever and chills
- ☐ General aching
- ☐ Sleeping problems
- ☐ Unintentional weight gain
- ☐ Unintentional weight loss

EYES:
- ☐ Loss of vision
- ☐ Pain in one or both eyes

EARS, NOSE, MOUTH AND THROAT:
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Hoarseness or other voice changes
- ☐ Snoring
- ☐ Sore throat

CARDIOVASCULAR:
- ☐ Blacking out/fainting
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Leg cramps or leg pain with short distance walking
- ☐ Shortness of breath only when lying down
- ☐ Shortness of breath while sitting or standing
- Swelling including ankles or legs

☐ **RESPIRATORY:**
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Snoring
- Wheezing

☐ **GASTROINTESTINAL:**
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal pain
- ☐ Painful swallowing
- Vomiting

☐ **PSYCHOLOGICAL:**
- ☐ Arrested for driving while intoxicated
- ☐ Difficulty maintaining long-term relationships
- ☐ Easily upset or irritated
- ☐ Feels nervous
- ☐ Feels sad more than usual
- ☐ Suicidal attempts or gestures in the past
- ☐ Suicidal thoughts
- Trouble sleeping

Yes

ENDOCRINE:
- ☐ Increased appetite
- ☐ Decreased interest in sex
- ☐ Increased thirst
- ☐ Urinating more than usual

GENITOURINARY:
- ☐ Pain during sex
- ☐ Blood in urine
- ☐ Difficulty starting or stopping urination
- ☐ Difficulty holding urine
- ☐ Dripping after urination
- ☐ Hesitancy when urinating
- ☐ Incontinence with coughing, sneezing, laughing or straining
- ☐ Pain or burning with urination

MUSCULOSKELETAL (BONES, JOINTS AND MUSCLES):
- ☐ Bone deformities
- ☐ Decreased in sizes of muscles
- ☐ Loss of muscle strength
- ☐ Muscle pain
- ☐ Painful joints
- ☐ Stiffness in joints
- ☐ Stiffness in neck
- ☐ Swelling of joints
- ☐ Weakness

INTEGUMENTARY (SKIN):
- ☐ Poor wound healing
- ☐ Skin itching
- ☐ Skin rashes
- ☐ Ulcers

NEUROLOGICAL:
- ☐ Difficulty remembering
- ☐ Difficulty in thinking
- ☐ Difficulty walking
- ☐ Difficulty with balance
- ☐ Difficulty with coordination
- ☐ Headache
- ☐ Loss of bladder control
- ☐ Loss of bowel control
- ☐ Seizures
- ☐ Tremors
- ☐ Paralysis

HEMATOLOGICAL/ LYMPHATIC:
- ☐ Bleeds excessively after injury or minor surgery
- ☐ Bruises easily
- ☐ Bone pain
- ☐ Uses blood thinners

ALLERGIC, INFECTIOUS AND IMMUNOLOGIC:
- ☐ Food intolerance
- ☐ Infections recurring
- ☐ Multiple aching joints with fever
- ☐ Rash after contact with specific substance
- ☐ History of MRSA infection

For Motor Vehicle or Work Injuries

Motor Vehicle accident? ☐ Yes ☐ No Any previous accidents? ☐ Yes ☐ No

Work related? ☐ Yes ☐ No Any previous injuries? ☐ Yes ☐ No

Date of injury: _____

Are you in litigation? ☐ Yes ☐ No

Describe in detail how your injury occurred:

_____

_____

_____

_____

_____

_____

Did you have immediate pain? ☐ Yes ☐ No

Did you seek treatment immediately? ☐ Yes ☐ No Where? _____

What kind of treatment? _____

If you were involved in a motor vehicle accident, please answer the following:

Driver? ☐ Yes ☐ No Head on? ☐ Yes ☐ No Tail spin? ☐ Yes ☐ No

Passenger? ☐ Yes ☐ No Broadside? ☐ Yes ☐ No Rollover? ☐ Yes ☐ No

Seatbelt? ☐ Yes ☐ No Rear end? ☐ Yes ☐ No

If a police report was filed, please attach a copy, along with any other records or documentation pertinent to this case.

I hereby confirm that all of the above information is true to the best of my knowledge. I give consent to history taking and physical examination by Spine Pain Diagnostics Associates physicians and their designees.

_____ Date: _____
Signature of patient or legal representative

_____ Date: _____
Person assisting with filling out this questionnaire

OZAUKEE SURGERY CENTER
PAIN DIAGNOSTICS ASSOCIATES
A Division of Wisconsin Michigan Physicians

INITIAL LEARNING ASSESSMENT

Name: **Date:** _____

DOB: **Physician: V. Singh, MD / C. Piryani, MD**

MR#:

During your visit with our organization you will be presented with information that may be new to you. To aid us in providing this information to you in a manner that allows for optimal understanding, please answer the following questions.

1. How do you like to learn new things? Please check all that apply.
   ☐ Verbal ☐ Written ☐ Visual
2. Do you speak English in your home? ☐ Yes ☐ No
   If no, what language do you speak? _____
   Name of Interpreter: _____
3. Can you read English? ☐ Yes ☐ No
4. Can you write English? ☐ Yes ☐ No
5. Can you hear well? ☐ Yes ☐ No
   If no, do you use a hearing device? ☐ Yes ☐ No
6. Do you need to receive information through sign language? ☐ Yes ☐ No
7. Do you see well? ☐ Yes ☐ No
   If no, do you wear glasses or contacts? ☐ Yes ☐ No
8. Do you forget things easily? ☐ Yes ☐ No
9. Do you feel your level of pain interferes with learning? ☐ Yes ☐ No
10. Do you feel the need to have a family member or someone present during education? ☐ Yes ☐ No
11. Do you have any cultural or religious practices/beliefs that may affect our care or treatment? ☐ Yes ☐ No
    If yes, please explain: _____

Patient Signature: _____ Date: _____

Staff Use Only

STAFF ASSESSMENT

1. **Barriers to Patient Teaching/Learning:**

   ☐ None Identified
   ☐ Reading Barrier
   ☐ Hearing Impairment
   ☐ Visual Impairment
   ☐ Cognitive Impairment
   ☐ Pain Level
   ☐ Cultural
   ☐ Lack of Motivation
   ☐ Emotional
   ☐ Other: _____

OZAUKEE SURGERY CENTER
PAIN DIAGNOSTICS ASSOCIATES
A Division of Wisconsin Michigan Physicians

INITIAL LEARNING ASSESSMENT

2. Patient / Family readiness to Learn:

   Accurately explains reason for visit and relates medical history? ☐ Yes ☐ No

   Verbalizes readiness and willingness to learn about plan of care? ☐ Yes ☐ No

3. Preferred Method of Learning:

   ☐ Verbal ☐ Written ☐ Demonstration

4. Patient / Family verbalized understanding of information provided? ☐ Yes ☐ No

   If no, please explain: _____

   _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Staff Signature: _____ Date: _____

Physician Signature: _____ Date: _____

OSC / SPDA
NUTRITIONAL RISK ASSESSMENT

Patient name: _____
MR #: _____
DOB: _____

Vijay Singh, MD
Piryani, MD , MD

Deterioration in health and loss of independence may result from under nutrition and perhaps malnutrition. The following questions will help determine if any action may be needed to assist with achieving proper nutrition.

1. Unintentional weight LOSS ?	Yes No
2. Reduced appetite or reduced food or fluid intake?	Yes No
3. Underweight - affecting life quality?	Yes No
4. Unintentional weight GAIN ?	Yes No
5. Overweight - affecting life quality?	Yes No
6. Mouth or teeth or swallowing problem?	Yes No
7. Following a special diet?	Yes No
8. Unable to shop for food?	Yes No
9. Unable to prepare food?	Yes No
10. Unable to feed self?	Yes No

Patient Signature: _____ Date: _____

If *yes* to one or more questions, nutritional risk may exist - recommend patient discuss this risk with Primary Care Provider (PCP) to further determine if need for dietary consultation is necessary.

Copy given to patient & instructed to bring to PCP: □ Yes □ N/A

Clinical Staff Signature: _____ Date: _____

Physician Signature: _____ Date: _____

SPINE PAIN DIAGNOSTICS ASSOCIATES/ OZAUKEE SURGERY CENTER

A Division of Wisconsin Michigan Physicians

V. Singh, MD C. Piryani, MD

Name: _____ Date: _____

MR # : _____

DOB: _____

BACK OR LEG PAIN

These questions are designed to give us more detailed information as to how your **BACK OR LEG** pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you.

Section 1: Pain Intensity

☐ 0. I have no pain at the moment
☐ 1. The pain is very mild at the moment
☐ 2. The pain is moderate at the moment
☐ 3. The pain is fairly severe at the moment
☐ 4. The pain is very severe at the moment
☐ 5. The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing)

☐ 0. I can look after myself normally without causing extra pain
☐ 1. I can look after myself normally but it causes me extra pain
☐ 2. It is painful to look after myself and I am slow and careful
☐ 3. I need some help but can manage most of my personal care
☐ 4. I need help every day in most aspects of my personal care
☐ 5. I do not get dressed; wash with difficulty; stay in bed

Section 3: Lifting

☐ 0. I can lift heavy weight without extra pain
☐ 1. I can lift heavy weight but it gives me extra pain
☐ 2. Pain prevents me from lifting heavy weight off the floor but I can manage if it is easily placed (on a table)
☐ 3. Pain prevents me lifting heavy weight but I can manage light to medium weight if it is easily placed
☐ 4. I can only lift very light weight
☐ 5. I cannot lift or carry anything

Section 4: Walking

☐ 0. Pain does not prevent me walking any distance
☐ 1. Pain prevents me from walking more than 1 mile
☐ 2. Pain prevents me from walking more than ¼ mile
☐ 3. Pain prevents me from walking more than 100 yards
☐ 4. I can only walk using a cane, crutches or walker
☐ 5. I am in bed most of the time

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 one hour
☐ 3. Pain prevents me from sitting more than 30 minutes
☐ 4. Pain prevents me from sitting more than 10 minutes
☐ 5. Pain prevents me from sitting at all

Section 6: Standing
☐ 0. I can stand as long as I want without extra pain
☐ 1. I can stand as long as I want but it gives me extra pain
☐ 2. Pain prevents me from standing for more than one hour
☐ 3. Pain prevents me from standing for more than 30
☐ 4. Pain prevents me from standing more than 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 have less than 6 hours sleep
☐ 3. Because of pain I have less than 4 hours sleep
☐ 4. Because of pain I have less than 2 hours sleep
☐ 5. Pain prevents me from sleeping at all

Section 8: Sex Life
☐ 0. My sex life is normal and causes no extra pain
☐ 1. My sex life is normal but causes some extra pain
☐ 2. My sex life is nearly normal but is very painful
☐ 3. My sex life is severely restricted by pain
☐ 4. My sex life is nearly absent because of pain
☐ 5. Pain prevents any sex life at all

Section 9: 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 significant effect on my social life except for limiting my more energetic interests (sports, etc.)
☐ 3. Pain has restricted my social life and I do not go out as often
☐ 4. Pain has restricted my social life to my home
☐ 5. I have no social life because of pain

Section 10: Travel
☐ 0. I can travel anywhere without pain
☐ 1. I can travel anywhere but it gives me extra pain
☐ 2. Pain is bad but I manage journeys over 2 hours
☐ 3. Pain restricts me to journeys of one hour
☐ 4. Pain restricts me to short necessary journeys of less than 30 minutes
☐ 5. Pain prevents me from traveling except to receive treatment

Patient Signature: _____ Date: _____

Admitting Signature: _____ Score: _____ Date: _____

Physician Signature: _____ Date: _____

SPINE PAIN DIAGNOSTICS ASSOCIATES/ OZAUKEE SURGERY CENTER

A Division of Wisconsin Michigan Physicians

V. Singh, MD C. Piryani, MD

Name: _____ Date: _____

MR #: _____

DOB: _____

NECK PAIN

These questions are designed to give us more detailed information as to how your **NECK** pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you.

Section 1: Pain Intensity

☐ 0. I have no pain at the moment
☐ 1. The pain is very mild at the moment
☐ 2. The pain is moderate at the moment
☐ 3. The pain is fairly severe at the moment
☐ 4. The pain is very severe at the moment
☐ 5. The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing)

☐ 0. I can look after myself normally without causing extra pain
☐ 1. I can look after myself normally but it causes me extra pain
☐ 2. It is painful to look after myself and I am slow and careful
☐ 3. I need some help but can manage most of my personal care
☐ 4. I need help every day in most aspects of my personal care
☐ 5. I do not get dressed; wash with difficulty; stay in bed

Section 3: Lifting

☐ 0. I can lift heavy weight without extra pain
☐ 1. I can lift heavy weight but it gives me extra pain
☐ 2. Pain prevents me from lifting heavy weight off the floor but I can manage if it is conveniently placed (on a table)
☐ 3. Pain prevents me lifting heavy weight but I can manage light to medium weight if it is conveniently placed
☐ 4. I can only lift very light weight
☐ 5. I cannot lift or carry anything

Section 4: Reading

☐ 0. I can read as much as I want with no pain in my neck
☐ 1. I can read as much as I want with slight pain in my neck
☐ 2. I can read as much as I want with moderate pain in my neck
☐ 3. I cannot read as much as I want because of moderate pain in my neck
☐ 4. I can hardly read at all because of severe pain in my neck
☐ 5. I cannot read at all because of severe pain in my neck

Section 5: Headaches

☐ 0. I have no headache at all
☐ 1. I have slight headaches that come infrequently
☐ 2. I have moderate headaches that come infrequently
☐ 3. I have moderate headaches that come frequently
☐ 4. I have severe headaches that come frequently
☐ 5. I have headaches almost all the time

SPINE PAIN DIAGNOSTICS ASSOCIATES/ OZAUKEE SURGERY CENTER

A Division of Wisconsin Michigan Physicians

V. Singh, MD C. Piryani, MD

Section 6: Concentration

☐ 0. Pain has no effect on my concentration
☐ 1. Pain has slight effect on my concentration
☐ 2. Pain has a moderate effect on my concentration
☐ 3. I have a lot of difficulty concentrating because of the pain
☐ 4. I have a great deal of difficulty concentrating because of the pain
☐ 5. I cannot concentrate at all because of the pain

Section 7: Work

☐ 0. I can do as much work as I want to
☐ 1. I can do my usual work but no more
☐ 2. I can do most of my usual work but no more
☐ 3. I cannot do my usual work
☐ 4. I can hardly do any work at all
☐ 5. I cannot do any work at all

Section 8: Driving

☐ 0. I can drive without any neck pain
☐ 1. I can drive as long as I want with slight neck pain
☐ 2. I can drive as long as I want with moderate neck pain
☐ 3. I cannot drive as long as I want because of moderate neck pain
☐ 4. I can hardly drive at all because of severe neck pain
☐ 5. I cannot drive at all because of severe neck pain

Section 9: Sleeping

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

Section 10: Recreation

☐ 0. I can engage in all my recreation activities with no neck pain
☐ 1. I can engage in all my recreation activities with some neck pain
☐ 2. I can engage in most of my recreation activities because of neck pain
☐ 3. I can engage in few of my recreation activities because of neck pain
☐ 4. I can hardly do any recreation activities because of neck pain
☐ 5. I cannot do any recreation activities at all

Patient Signature: _____ Date: _____

Admitter Signature: _____ Score: _____ Date: _____

Physician Signature: _____ Date: _____

OSC / SPDA has instituted the following updated protocol until further notice.

Effective 4/25/23

1. **It is your responsibility to call us prior to arriving for your appointment if you have any symptoms of illness.**

2. We are allowing **one** accompany **adult** into **the waiting area** at this time.

3. Enter the facility, check in with the receptionist and take a seat.

4. Masks are optional unless you have symptoms of an illness. If you are displaying any symptoms, especially respiratory symptoms, we require you to wear a mask for the entirety of your appointment.

5. As a reminder, we are a smoke free facility **and grounds, this includes in your vehicle & the parking lot**. Please be respectful of this.

6. If you become aware that you had contact with a COIVD-19 positive person or someone pending a COIVD-19 test, **we ask you to contact this office within 24 hours to notify us**.

7. Following the appointment(s), if you were tested for COIVD-19 and have a positive result or develop symptoms, **we ask you to contact this office within 24 hours to notify us.**

Patient signature:_____ **Date:**_____