Brett Bailey

International case manager

Personal Data - Cervical

Name	
Address	
Phone	
E-Mail	
Birthdate (mm/dd/yy)	
Gender	
Height	
Weight	
Occupation	

If you are a candidate for surgery what month is best for you?

Pain history

Length of time

Describe numbness, weakness, neurological deficits, leg pain (if any, left/right/both)

What makes pain worse?

Walking tolerance (minutes or distance)

Standing tolerance (minutes)

Sitting tolerance (minutes)

Previous spine surgeries

Other surgeries

Medications (spine related & pain patches too)

Medications (other)

A**llergies (medications, metals, etc.)**

Cervical pain history

(Accidents, events requiring visit to doctor, conservative treatment for spine problem etc.)

Event	Date	Data/Films	Description

Personal medical history (answer yes/no. Detail if necessary)

Cardiovascular diseases

Blood pressure/ hypertension	
Stroke	
Heart trouble	
Irregular heartbeat	
Blood clots/ embolism	

Respiratory system

Nose throat problem	
Breathing problem	
Chest pain	
Asthma	
Pneumonia	
Tuberculosis	

Hormonal/ metabolic diseases

Diabetes	
Thyroid problem	

Diseases of the nerve system

Migraine headache	

Nervous breakdown	
Eye problems	
Epilepsy	
Depression	

Gastrointestinal tract/organs

Stomach problem	
pyrosis	
Colitis	
Hepatitis/ Jaundice	
Kidney problems	

Infectious diseases

AIDS positive	
Hepatitis	

Blood diseases/ Anemia/ Transfusion

Bleeding problem	
Transfusion	
Anemia	

Joint/bone diseases

Lupus	

Arthritis

Back problems (other)

Osteoporosis

Cancer

Details

Habit details (Please note all information is strictly confidential)

Consumption (daily, weekly, etc.)

Alcohol

Cigarettes

Drugs (Cannabis, etc.)

Homeopathic

Other

Case history – work involvement and leisure time activities

The physical strain in job and leisure time plays a major role for orthopedic diagnosis and therapy. This questionnaire will therefore help us to help you.

1. What is the profession you work in?

2. Have you had to stop working or change jobs because of your condition? ☐ Yes ☐ No

If yes, when?

What job are you working in at present?

3. You are working under these conditions.

Fulltime ☐

Part-time ☐

A few hours per day ☐

4. Is your job physically straining for you? ☐ Yes ☐ No

Is it associated with monotonous body postures? ☐ Yes ☐ No

Does your status make it difficult to work? ☐ Yes ☐ No

5. Do your complaints allow you to do sports? ☐ Yes ☐ No

If yes, what kind of sports are you doing?

Did you do any sports before? ☐ Yes ☐ No

If yes, what kind of sports?

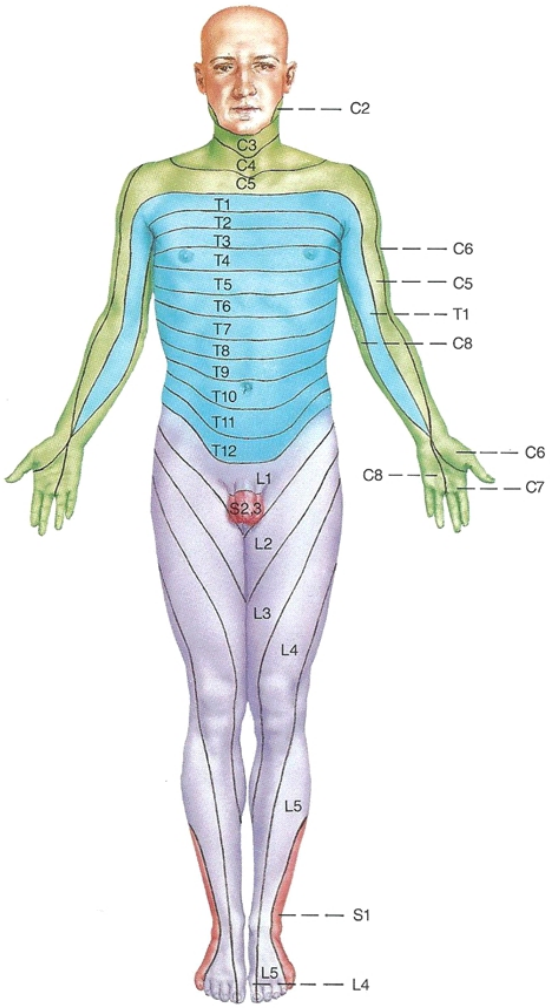
6. Will you have someone to support you at home after surgery? ☐ Yes ☐ No

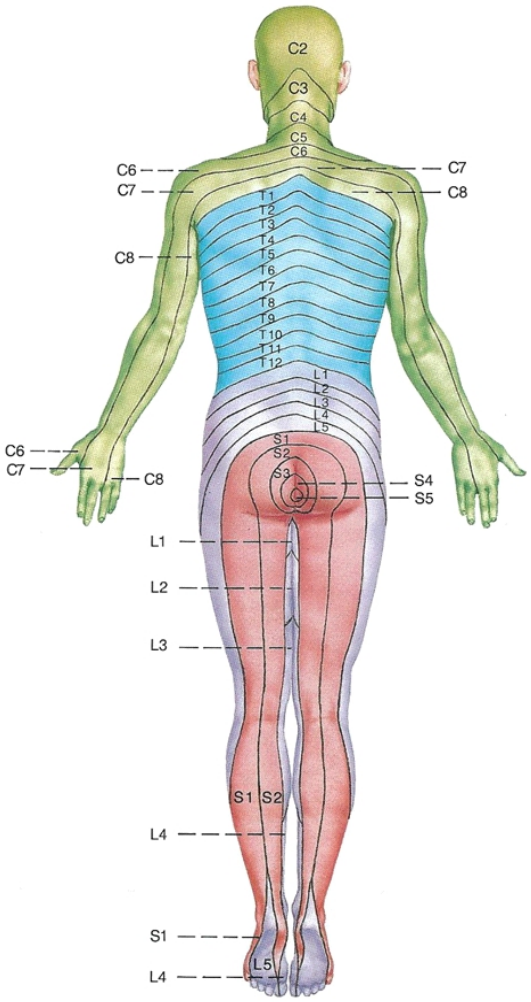
Who would help you?

Body scheme

Please describe your pain using the zones on the two images:

For example: C6 – pain/numbness/tingling





Visual Analogue Scale / Patient Satisfaction

The visual analog scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

Neck pain:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No pain worst possible pain

Left Arm pain:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No pain worst possible pain

Right Arm Leg pain:

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No pain worst possible pain

Owestry Disability Index

This questionnaire is designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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, etc.)

☐ (0) I can look after myself normally without causing extra pain.

☐ (1) I can look after myself normally but it is very painful.

☐ (2) It is painful to look after myself and I am slow and careful.

☐ (3) I need some help but manage most of my personal care.

☐ (4) I need help every day in most aspects of self care.

☐ (5) I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

☐ (0) I can lift heavy weights without extra pain.

☐ (1) I can lift heavy weights but it gives extra pain.

☐ (2) Pain prevents me from lifting heavy weights off the floor but I can-manage if they are conveniently positioned, for example on a table.

☐ (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.

☐ (4) I can lift only very light weights.

☐ (5) I cannot lift or carry anything at all.

Section 4 – Walking

☐ (0) Pain does not prevent me from walking any distance.

☐ (1) Pain prevents me 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 stick or crutches.

☐ (5) I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

☐ (0) I can sit in any chair as long as I like.

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 1 hour.

☐ (3) Pain prevents me from standing for more than ½ hour.

☐ (4) Pain prevents me from standing for 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 (if applicable)

☐ (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 causes no extra pain.

☐ (1) My social life is normal but increases the degree of pain.

☐ (2) Pain has no significant effect on my social life apart from limiting my more energetic interests such as sports, dancing, etc.

☐ (3) Pain has restricted my social life and I do not go out as often.

☐ (4) Pain has restricted my social life to my home.

☐ (5) I have no social life because of pain.

Section 10 – Traveling

☐ (0) I can travel anywhere without extra pain.

☐ (1) I can travel anywhere but it gives extra pain.

☐ (2) Pain is bad but I mange journeys over 2 hours.

☐ (1) I can 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 ½ hour. ☐ (4) Pain prevents me from sitting more than 10 minutes. ☐ (5) Pain prevents me from sitting at all.	☐ (3) Pain restricts me to short journeys of less than 1 hour. ☐ (4) Pain restricts me to short necessary journeys of less than 30 minutes. ☐ (5) Pain prevents me from traveling except to receive treatment.

Neck Disability Index

This questionnaire is designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

- ☐ (0) I can read as much as I want to, with no pain in my neck.
- ☐ (1) I can read as much as I want to, with slight pain in my neck.
- ☐ (2) I can read as much as I want to, with moderate pain in my neck.
- ☐ (3) I can't 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.

Section 6 – Concentration

- ☐ (0) I can concentrate fully when I want to with no difficulty.
- ☐ (1) I can concentrate fully when I want to with slight difficulty.
- ☐ (2) I have a fair degree of difficulty in concentrating when I want to.
- ☐ (3) I have a lot of difficulty in concentrating when I want to.
- ☐ (4) I have a great deal of difficulty in concentrating when I want to.
- ☐ (5) I cannot concentrate at all.

Section 7 – Work

- ☐ (0) I can do as much work as I want to.
- ☐ (1) I can only 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 can't do any work at all.

Section 8 – Driving

- ☐ (0) I can drive my car without any neck pain.
- ☐ (1) I can drive my car as long as I want, with slight pain in my neck.
- ☐ (2) I can drive my car as long as I want, with moderate pain in my neck.
- ☐ (3) I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ (4) I can hardly drive at all because of severe pain in my neck.
- ☐ (5) I can't drive my car at all.

Section 9 – Sleeping

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

Section 5 – Headaches

☐ (0) I have no headaches 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.

Section 10 – Recreation

☐ (0) I am able to engage in all my recreation activities with no neck pain at all.

☐ (1) I am able to engage in all my recreation activities with some pain in my neck.

☐ (2) I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.

☐ (3) I am able to engage in a few of my usual recreation activities because of pain in my neck.

☐ (4) I can hardly do any recreation activities because of pain in my neck.

☐ (5) I can't do any recreation activities at all.

SF-36

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

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now?</u>

Much better now	Somewhat better now	About the same	Somewhat worse now	Much worse now
☐	☐	☐	☐	☐

3. The following questions are about activities you might do during a typical day. Does your health <u>now</u> limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a) **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b) **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c) Lifting or carrying groceries	☐	☐	☐
d) Climbing **several** flights of stairs	☐	☐	☐
e) Climbing **one** flight of stairs	☐	☐	☐
f) Bending, kneeling, or stooping	☐	☐	☐
g) Walking **more than a mile**	☐	☐	☐
h) Walking **several blocks**	☐	☐	☐
i) Walking **one block**	☐	☐	☐
j) Bathing or dressing yourself	☐	☐	☐

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?

	Yes	No
a) Cut down on the **amount of time** you spent on work or other activities	☐	☐
b) **Accomplished less** than you would like	☐	☐
c)Were limited in the **kind** of work or other activities	☐	☐
d) Had **difficulty** performing the work or other activities (for example, it took extra effort)	☐	☐

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)?

	Yes	No
a) Cut down on the **amount of time** you spent on work or other activities	☐	☐
b) **Accomplished less** than you would like	☐	☐
c) Didn't do work or other activities as **carefully** as usual	☐	☐

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very severe
☐	☐	☐	☐	☐	☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not ar all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

9. 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 <u>past 4 weeks</u>...

	All of the time	Most of the time	A Good Bit of the Time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b) Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
c) Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
d) Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e) Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f) Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
g) Did you feel worn out?	☐	☐	☐	☐	☐	☐
h) Have you been a happy person?	☐	☐	☐	☐	☐	☐
i) Did you feel tired?	☐	☐	☐	☐	☐	☐

10. During the <u>past 4 weeks</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

11. How TRUE or FALSE is <u>each</u> of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b) I am as healthy as anybody I know	☐	☐	☐	☐	☐
c) I expect my health to get worse	☐	☐	☐	☐	☐
d) My health is excellent	☐	☐	☐	☐	☐

Optional note:

How did you hear about us?

Patient Initials:

Date