CERVICAL Orthopedic Specialists of Louisiana Pierce D. Nunley, MD

PERSONAL INFORMATION

(Please Print or Type)

Patient Name: ____________________________ ____________________________ ________
Last First MI

Registration Date: _____/_____/_____ Birthdate: _____/_____/_____ Age: ______
Social Security #: _________-______-__________ Sex: ______

Address: ____ Apt. # ________
Street

__________________________________ ________ ____________________
City State Zip

Telephone Numbers: (_______)____________________ (_______)______________________
Home Phone Work Phone

Occupation: ____

Employer: ____
Name

____ (_____)__________________________
Street Phone Number

__________________________________ ________ ____________________
City State Zip

Dates of Injury:
First Injury : _____/_____/_____
Second Injury: _____/_____/_____
Third Injury : _____/_____/_____
Fourth Injury: _____/_____/_____

Referring Source: ____
Name

____ (_____)_______________
Street Phone Number

____________________________ ________ ____________________
City State Zip

Referring Source is:
1) Physician 2) Chiropractor 3) Other Healthcare Professional
4) Another Patient 5) Workers Comp 6) Friend
7) Yellow Pages 8) Other ______________________________________

Family Physician: ____

Emergency Contact: (A person not living at your residence)
Name: ______________________________________ City: _________________ State: ____
Work Phone: (_____)______________ Home: (______)_________________

Spouse Information:
Name: ____________________________________ ______________________ _____
Last First MI
Birthdate: ____/____/____ Social Security Number: ________-_____-__________
Employer: ______________________________________ Work Phone: (____)____________

Attorney: (Complete only if an attorney is representing you for this injury)

____
Name

____ (_____)_______________________
Street Phone Number

____________________________ ________ ____________________
City State Zip

Do you want a copy of this report sent to your attorney? (**Circle One**) **YES** **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Company ______________________ Phone Number (____)__________

Street ______________________ Suite __________

City __________ State ______ Zip ______

Group #: ______________ Policy or ID #: ______________

Subscriber's Name: ______________________

RELATIONSHIP: (**Circle One**) Self Spouse Mother Father

SECONDARY INSURANCE:

Insurance Company ______________________ Phone Number (____)__________

Street ______________________ Suite __________

City __________ State ______ Zip ______

Group #: ______________ Policy or ID #: ______________

Subscriber's Name: ______________________

RELATIONSHIP: (**Circle One**) Spouse Mother Father Self

WORKERS COMPENSATION:

Insurance Company ______________________ Phone Number (____)__________

Street ______________________ Suite __________

City __________ State ______ Zip ______

File or Claim #: ______________ Case Manager: ______________

Employer **at the Time of Injury**:

Company ______________________ Phone Number (____)__________

Street ______________________ Suite __________

City __________ State ______ Zip ______

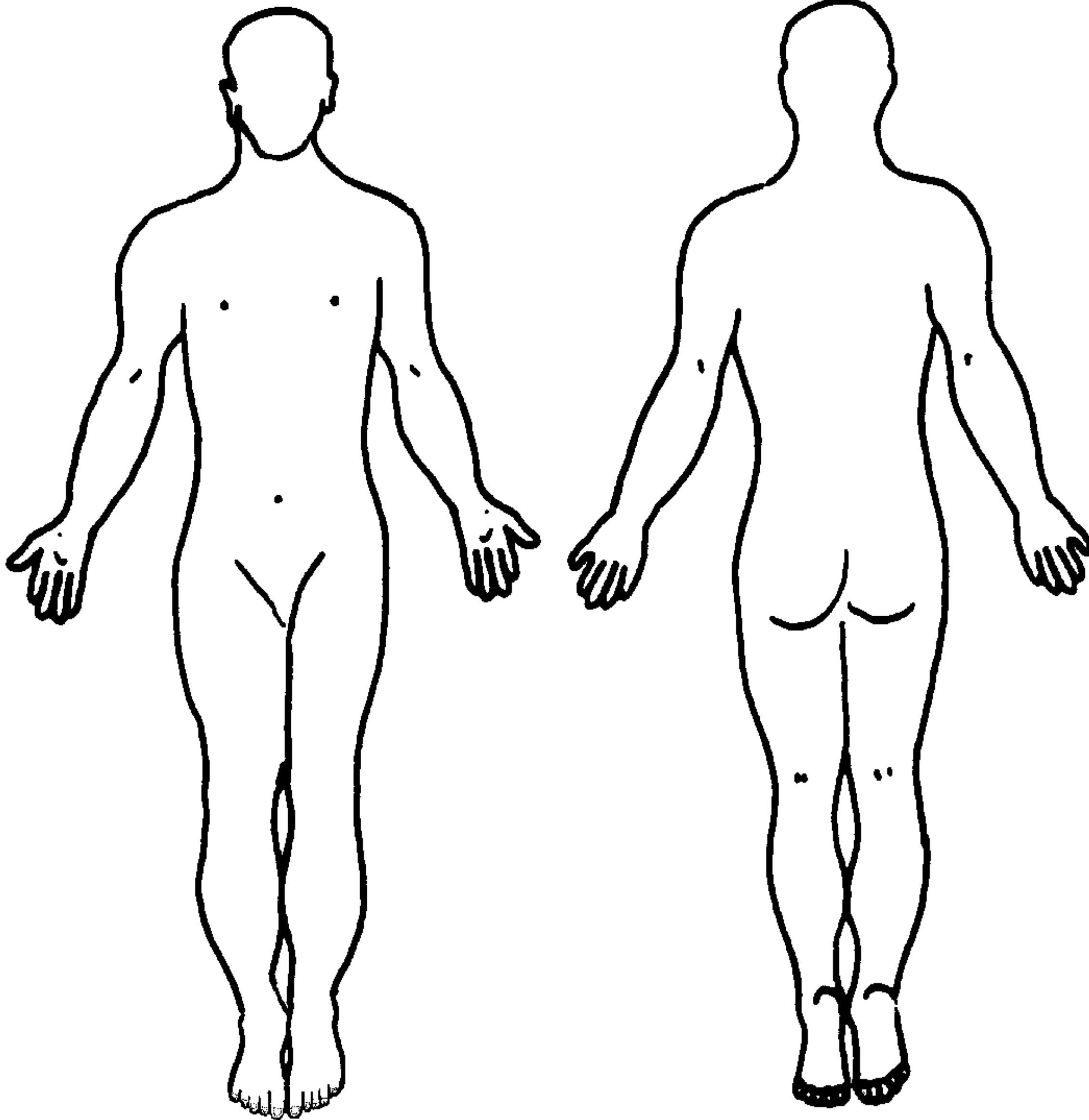
Patient:______________________

PAIN DRAWING

Date:____________

DRAW the location of your pain on the body outlines below.

FRONT VIEW **BACK VIEW**



On a scale of 1 to 10 with 1 being no pain and 10 being intolerable pain, **CIRCLE** the number that would indicate your **pain level**.

Today:	1	2	3	4	5	6	7	8	9	10
The Least it ever gets:	1	2	3	4	5	6	7	8	9	10
The Most it ever gets:	1	2	3	4	5	6	7	8	9	10
Most Mornings:	1	2	3	4	5	6	7	8	9	10
Most Days:	1	2	3	4	5	6	7	8	9	10
Most Evenings:	1	2	3	4	5	6	7	8	9	10
Most Nights:	1	2	3	4	5	6	7	8	9	10

CERVICAL SPINE HISTORY

CERVICAL HISTORY OF PRESENT ILLNESS

1. When did your present pain **BEGIN** (please be as specific as possible)? ____________________
2. Please give the **DETAILS** of your present injury in the space provided:

____

____

____

____

____

3. Using the following chart, please **Circle** how long you have had your present pain:

1 = Less than one month	3 = 2 to 3 months	5 = 6 months to a year
2 = 1 to 2 months	4 = 3 to 6 months	6 = More than a year

4. Using the following chart, please indicate how your present pain began (**CIRCLE all that apply**):

1 =	Unknown	6 =	Occurred while walking
2 =	Occurred while sitting	7 =	Occurred during an athletic activity
3 =	Occurred while bending	8 =	Occurred as a result of an auto accident
4 =	Occurred while lifting	9 =	Occurred as a result of a fall
5 =	Occurred while twisting	10 =	Occurred as a result of a trauma

11 = Other - Please Explain Briefly ______________________________________

5. Is this injury work related?

1 = **Yes** 2 = **No** 3 = **Unsure**

6. Please indicate where your present pain was initially located: (**CIRCLE ONE**)

1 = Unknown	4 = Mid Neck	7 = Arms
2 = Base of Skull	5 = Lower Neck	8 = Hands
3 = Upper Neck	6 = Shoulders	

7. How have the symptoms of your present pain changed since they began?

1 = No change in symptoms
2 = Increased aggravation in neck
3 = Increased aggravation in shoulders
4 = Increased aggravation in arms
5 = Increased aggravation in neck & arms

8. Please **CIRCLE** the most appropriate statement:

1 = My symptoms have remained the same since the time of injury
2 = My symptoms are more severe since the time of injury
3 = My symptoms are less severe since the time of injury

9. Compare the Pain in your NECK to the pain in your (Shoulder, Arm, & Hand)? (**Circle One**)

1 = 100% Neck pain and 0% Shoulder, Arm, & Hand pain
2 = 80% Neck pain and 20% Shoulder, Arm, & Hand pain
3 = 60% Neck pain and 40% Shoulder, Arm, & Hand pain
4 = 50% Neck pain and 50% Shoulder, Arm, & Hand pain
5 = 40% Neck pain and 60% Shoulder, Arm, & Hand pain
6 = 20% Neck pain and 80% Shoulder, Arm, & Hand pain
7 = 0% Neck pain and 100% Shoulder, Arm, & Hand pain

10. Circle **ANY** and **ALL** areas of weakness (Right, Midline, and/or Left):

NECK	-	Right	Midline	Left
SHOULDERS(s)	-	Right		Left
ARMS	-	Right		Left
HANDS	-	Right		Left
HIPS	-	Right		Left
LEGS/FEET	-	Right		Left

11. Please rate your pain over recent weeks using the following scale:

1 = no pain
2 = mild pain
3 = moderate requiring mild pain medications such as Tylenol or aspirin
4 = severe causing you to markedly modify your activities and/or take strong medications such as codeine or other narcotics and prescription drugs
5 = so intense you can barely function
6 = so excruciating that it is unbearable

1)	At its worst	1	2	3	4	5	6
2)	Most of the time (usual)	1	2	3	4	5	6
3)	At its best (least)	1	2	3	4	5	6
4)	In the morning:						
	a) before getting out of bed	1	2	3	4	5	6
	b) after getting out of bed	1	2	3	4	5	6
5)	Midday	1	2	3	4	5	6
6)	Evening	1	2	3	4	5	6
7)	Night time	1	2	3	4	5	6

12. Which of the following activities **CHANGES** your pain? (checkmark (√) all that apply):

		Aggravates Pain	Relieves Pain
1	Turning Head	________	________
2	Looking Down	________	________
3	Looking Up	________	________
4	Lifting	________	________
5	Driving	________	________
6	Standing	________	________
7	Walking	________	________
8	Lying on your side	________	________
9	Lying on your back	________	________
10	Lying on your stomach	________	________
11	Coughing/sneezing	________	________

Now go back and put an asterisk (*) next to the most aggravating activity and the most relieving activity.

13. Please estimate how many hours you spend from 7:00 a.m. to 11:00 p.m. each day performing the following activities:

1	Working	______	5	Sitting	______
2	Driving	______	6	On couch/recliner	______
3	Housekeeping	______	7	In bed	______
4	Walking	______	8	Other major activity	______

PAST CERVICAL HISTORY

14. Which of the following treatments have you tried? Please place a checkmark (√) to indicate the effect of those which have been used in an attempt to heal your present injury.
(Do **NOT** mark those not tried):

		Not Helpful	Helpful	For How Long?
1)	Physical Therapy	________	________	________
2)	Epidural Block/Injections	________	________	________
3)	Facet Block/Injection	________	________	________
4)	Exercises	________	________	________
5)	Traction	________	________	________
6)	Hot Packs	________	________	________
7)	Ice Packs	________	________	________
8)	TENS Unit	________	________	________
9)	Ultrasound	________	________	________
10)	Neck School	________	________	________
11)	Chiropractor	________	________	________
12)	Acupuncture	________	________	________
13)	Other: ________________	________	________	________

15. Please indicate with a checkmark (√) if you have had any of the following studies.
Also, please indicate the Month & Year, if known:

1)	Plain X-ray of neck	____________	4)	Myelogram	____________
2)	CT scan	____________	5)	Discogram	____________
3)	MRI	____________	6)	EMG	____________

16. You have already given us the necessary information about your present pain; now please give the following information about any other previous episodes of neck problems.

1) Approximate dates:
   Episode A: ______/______/______
   Episode B: ______/______/______
   Episode C: ______/______/______
   Episode D: ______/______/______

2) Using the following chart, please **CIRCLE** the number(s) that indicate(s) where the symptoms of these other injuries were located:

Episode:		A	B	C	D
Unknown	=	1	1	1	1
Base of Skull	=	2	2	2	2
Neck	=	3	3	3	3
Shoulders	=	4	4	4	4
Arms	=	5	5	5	5
Hands	=	6	6	6	6
Lower Extremities	=	7	7	7	7

3) Using the following chart, please **CIRCLE** the number that indicates how long the symptoms of your other injuries lasted:

Episode:		A	B	C	D
Less than one month	=	1	1	1	1
1 to 3 months	=	2	2	2	2
3 to 6 months	=	3	3	3	3
6 months to one year	=	4	4	4	4
More than one year	=	5	5	5	5

4) Using the following chart, please **CIRCLE** the number that indicates the severity of your pain at the time of these other injuries:

Episode:		A	B	C	D
Mild pain	=	1	1	1	1
Moderate pain	=	2	2	2	2
Severe pain	=	3	3	3	3

CERVICAL SPINE SURGERY HISTORY

17. Have you had cervical (neck) surgery in the past? (**CIRCLE ONE**) **YES** **NO**

If you answered "**YES**" to the above question, please complete the following:

a) Give the details of all of your neck surgeries:

	Date	Doctor	Hospital	City/State
1st:	____/____/____	______________________	______________________	________________
2nd:	____/____/____	______________________	______________________	________________
3rd:	____/____/____	______________________	______________________	________________
4th:	____/____/____	______________________	______________________	________________

b) Please use the list below to indicate what was done in each procedure. Use all that apply.

1 = Unknown
2 = Laminectomy (also known as a "decompression") (Scar will be on back of neck)
3 = Disc removal from the Front (scar on front of neck)
4 = Disc removal from the Back (scar on back of neck)
5 = Fusion
6 = Placing or inserting screws, rods, cages, or other metal or synthetic devices
7 = Using bone graft from your body
8 = Using bone graft from a cadaver or bone bank
9 = Removing metal or other devices

1st surgery: = ___________
2nd surgery: = ___________
3rd surgery: = ___________
4th surgery: = ___________

c) Did you improve from your surgical procedure(s)?

1st Surgery: **YES** **NO**
2nd Surgery: **YES** **NO**
3rd Surgery: **YES** **NO**
4th Surgery: **YES** **NO**

MEDICAL, SOCIAL & VOCATIONAL HISTORY

MEDICATIONS

18. What medications do you take at the present time?

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

Now go back and put an asterisk (*) next to those medications which help relieve your pain.

19. List **ALL** allergies **and** the reactions they cause (e.g. "Sulfa drugs cause a rash"): _____________
____

MEDICAL/SURGICAL HISTORY

20. Have you been treated for any of the following? (Place a checkmark (√) on **ALL** that apply):

_____ High Blood Pressure
_____ Angina
_____ Heart Attack

_____ Asthma
_____ Bronchitis
_____ Pneumonia

_____ Diabetes

_____ Urinary Tract Infection

_____ Bleeding disorders
_____ Blood Transfusions
_____ Blood Clots in the legs
_____ Blood Clots in the lungs

_____ Hepatitis
_____ AIDS or HIV
_____ Stroke

21. List **ALL** other major illnesses not mentioned above that have been treated in the past 5 years:
____
____

22. List **ALL** previous surgeries, (excluding the surgeries already detailed):
____
____

23. Are you currently under a doctor's care for **ANY** medical condition? (**Circle One**) **YES** **NO**

24. List all other physicians with whom you have consulted in the past 5 years:

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

Now go back and put an asterisk (*) next to physicians you have seen in the past **6** months.

FAMILY HISTORY

25. Has anyone in your family ever had any of the following conditions? (**Circle ALL that apply**)

1 = Arthritis 2 = Back pain 3 = Neck pain 4 = Migraine headaches
5 = Tuberculosis 6 = Heart Trouble 7 = Cancer: Kind? ____________________________

SOCIAL HISTORY

26. Are you: (**CIRCLE ONE**) Single Married Divorced Separated Widowed

27. **Number** of children **and ages**, if any: ______________________

28. Are you: (**CIRCLE ONE**)

    1 = Unemployed 2 = Employed 3 = Student 4 = Retired

    If you answered "**1**" or "**2**", please answer the following questions:

    A) How long have you been off work this year?
        1 = No time
        2 = about 1 week
        3 = 2 to 4 weeks
        4 = 1 to 2 months
        4 = About 2 to 6 months
        5 = About 6 months to one year

    B) Are you presently working? (**CIRCLE ONE**) **YES** **NO**

    C) If you answered "no", please complete the following:

        1) What was the last date worked? ______/______/______

        2) Is your job still available? **YES** **NO**

        3) Was your reason for leaving work:
            a = Due to circumstances related to this problem
            b = Due to circumstances **NOT** related to this problem

29. Current source of income: (**CIRCLE ALL that apply**)

    1 = Spouse
    2 = Employer
    3 = Social Security
    4 = Disability
    5 = Unemployment
    6 = Workers Compensation
    7 = Family (other than spouse)
    8 = Other funds

30. Is your income sufficient to meet your needs? (**CIRCLE ONE**) **YES** **NO**

31. Are you a cigarette /cigar smoker? (**CIRCLE ONE**) **YES** **NO**
    If you answered "**YES**", how much do you smoke per day?

    1 = Less than 1/4 pack per day
    2 = 1/4 pack per day (5 cigarettes)
    3 = 1/2 pack per day (10 cigarettes)
    4 = 3/4 pack per day (15 cigarettes)
    5 = 1 pack per day
    6 = 2 packs per day
    7 = More than 2 packs per day
    8 = Other: ________________________

32. Do you drink alcoholic beverages? (**CIRCLE ONE**) **YES** **NO**
    If you answered "yes", please circle your average consumption.

    1 = Less than 4 drinks per month
    2 = 1 to 3 drinks per week
    3 = 3 to 6 drinks per week
    4 = 1 to 2 drinks per day
    5 = 3 to 5 drinks per day
    6 = More than 5 drinks per day

33. Have you used any "Street Drugs" in the last year? **YES** **NO**
    If you answered "**YES**", what drug(s) and how often? ______________________________
    ____

REVIEW OF SYSTEMS

34. Please **CIRCLE** any of the following problems which you now have or which you have had in the past 6 months:

General:
1 = weight gain
2 = weight loss
3 = appetite change
4 = marked fatigue
5 = unexplained night fever
6 = night sweats
7 = difficulty sleeping
8 = psychological difficulties

Joints:
1 = Pain
2 = Stiffness
3 = Redness
4 = Swelling

Lungs:
1 = Chest pain
2 = Recurring cough
3 = Wheezing

Cardiovascular:
1 = Chest pain, tightness
2 = Palpitations
3 = Shortness of breath with normal activities

Gastrointestinal:
1 = Uncontrolled loss of stool
2 = Persistent/recurring belly pain
3 = Diarrhea
4 = Blood in stool
5 = Heartburn
6 = Constipation
7 = Yellow jaundice
8 = Pain with bowel movement

Urological:
1 = Difficulty with urination
2 = Unable to control urine
3 = Pain with urination

Oswestry Pain Questionnaire

This questionnaire has been designed to give Dr Nunley information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section **ONLY ONE BOX** which 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 box which *most closely* describes your problem.

Section 1 -- Pain Intensity

❏ I can tolerate the pain I have without having to use pain killers
❏ The pain is bad but I manage without taking pain killers.
❏ Pain killers give complete relief from pain
❏ Pain killers give moderate relief from pain
❏ Pain killers give very little relief from pain
❏ Pain killers have no effect on the pain and I do not use them

Section 2 -- Personal Care (Washing, Dressing, etc)

❏ 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 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 from walking any distance
❏ Pain prevents me from walking more than 1 mile
❏ Pain prevents me from walking more than 1/2 mile
❏ Pain prevents me from walking more than 1/4 mile
❏ I can only walk using a stick 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 from sitting more than 1 hour
❏ Pain prevents me from sitting more than 1/2 hour
❏ 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 more than 1 hour
❏ Pain prevents me from standing more than 1/2 hour
❏ Pain prevents me from standing more than 10 minutes
❏ Pain prevents me from standing at all

Section 7 -- Sleeping

❏ Pain does not prevent me from sleeping
❏ I can sleep well only by using tablets
❏ Even when I take tablets I have less than six hours sleep
❏ Even when I take tablets I have less than four hours sleep
❏ Even when I take tablets I have less than two hours sleep
❏ Pain prevents me from sleeping at all

Section 8 -- Sex Life

❏ 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. dancing, 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 extra 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 the doctor or hospital

Number of Points: __________

Total Possible: __________

Score: __________%