Patient Information

Last Name: _____First Name: _____ Sex: ___
Date of Birth: _____ SS#: _____-____-_____
Address: _____ City: _____State: ___
Zip Code: _____ Work# ( ) ____-_____ Home# ( ) ____-_____
Mobile# ( ) ___-_____ Email: _____
Marital Status: Single___ Married ___ Divorced ___ Widowed ___ Domestic Partner___
Employer's Name: _____ Employer's Address_____
Referring Physician's Name: _____
Injury: Work or Auto related? _____ Date Accident Occurred: _____
Emergency Contact: _____ Phone# ( ) _____-_____

Insurance Information

Primary Insurance Co. Name: _____Policy#:_____
Subscriber Name: _____ SS#:___-___-____ Date of Birth: _____
Subscriber Employer's Name: _____

Secondary Insurance Co. Name: _____ Policy #:_____
Subscriber Name: _____ SS#:___-___-_____ Date of Birth: _____

Third Party Insurance Co. Name: _____ Claim #: _____
Adjustor's Name: _____ Adjustor's #:_____
State Accident Occurred: _____

Patient Questionnaire/ History

What is your Chief Complaint? _____
_____

Rate your chief complaint in order of severity from worst (5) to least (1)

Pain____ Decreased Motion____ Swelling/edema____ Stiffness____
Loss of function_____

Indicate the nature of your pain and symptoms: ___Sharp ___Dull ___Piercing ___Shooting ___Aching ___Deep ___Superficial ___Tingling ___Numbness ___Intermittent ___Burning ___Stabbing

When and how did this problem begin? _____
_____

What makes your symptoms/ pain worse? _____
_____
What makes your symptoms/ pain lessen? _____
Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____
Worst it has been_____ past 2 to 4 weeks_____ Past 24 hours_____ at this moment_____
Are your symptoms worse in the: _____Morning _____Afternoon _____Evening _____ Inconsistent_____

Are your symptoms: ___Improving ____Worse __Stable___

Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways._____

Please answer the following questions: By circling Yes or No
1) Do the current problems interrupt your sleep? Yes or No
2) Do have a history of Seizures? Yes or No
3) Have you had a history of headaches? Yes or No
4) Do you experience any dizziness or vertigo? Yes or No
5) Do you have a Pacemaker? Yes or No
6) Do you have any intolerance to hot or cold? Yes or No
7) Do you have any bruising or bleeding disorders? Yes or No
8) Have you had any skin changes, such as rashes or discoloration? Yes or No
9) Do you have any Metal Implants? Yes or No
10) Have you had a recent episode of nausea/vomiting? Yes or No
11) Are you pregnant? Yes or No
12) Do you have osteoporosis? Yes or No Date of your last bone scan:
13) Do you have any Medical allergies? Yes or No
14) Have you noticed any shortness of breath or in exercise tolerance? Yes or No
15) Do you use any assistive device? (Cane, foot orthotics) Yes or No
16) Do you have high blood pressure? Yes or No
17) Do you have any cardiac problems? Yes or No
18) Do you have diabetes? Yes or No
19) Have you ever had cancer of any sort? Yes or No
20) Do you have a history of neck or back problems? Yes or No
21) Do you have a hernia? Yes or No

Any other illness or past injuries I should be aware of? _____

Past surgeries: Yes ___No___
If yes, give brief details:

_____
List the medications you are currently taking (over the counter/prescriptions):

_____
_____

Use of Tobacco: Yes ____No ____ Use of Smokeless Tobacco: Yes ____No____

Patient's signature: _____Date Signed: _____

Specialists
HOSPITAL SHREVEPORT
Orthopedic & Spine Surgery
Physical Therapy · Pharmacy

WORKERS COMPENSATION ACKNOWLEDGEMNET FORM

Patient's Name: _____ Date of Birth: __/__/_

Street Address: _____ Social Security #: ____-___-_____

City/State/Zip: _____

Please check one of the following:

Is your visit today the result of a work-related injury? ☐ Yes ☐ No-**PLEASE SIGN AT BOTTOM**

Do you have an attorney? ☐ Yes ☐ No

If yes, Name of Attorney _____ Phone Number _____

Please be advised that if you are being seen as a result of a work-related injury you **MUST NOTIFY the front desk receptionist immediately.** If you fail to notify us of such a claim, your health insurance may deny coverage and you will ultimately be responsible for all charges related to medical care you receive at SPECIALISTS HOSPITAL SHREVEPORT

In the event that your Workers Compensation denies your case, you will be responsible for all charges related to medical care that you receive in this case and as a courtesy, we will file your primary health insurance company for payment, if applicable. If your insurance company denies due to their timely filling requirements, you will also be responsible.

We maintain strict guidelines on the processing of work-related claims. In order to process paperwork in a timely manner please provide us with the following information.

Workers Compensation Information

Workers Comp Carrier: _____ Claim #: _____ Date of Injury: _____

Adjustor's Name: _____ Adjustor's #:_____

Please signify your understanding of the matter by signing in the space provided below.

Patient Signature: _____ Date signed:

Specialists

Orthopedic & Spine Surgery

Physical Therapy • Pharmacy

Medicare Secondary Payer Questionnaire

1. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)

   ___No ___Yes

2. Are you receiving benefits from any of the following programs?

Black Lung	___No ___Yes
Research Grant	___No ___Yes
Veteran Affairs	___No ___Yes

3. Was the illness/injury due to a work related accident/condition?

   ___No ___Yes

   Date of injury/illness: _____

4. Was illness/injury due to a non-work related accident?

   ___No ___Yes

5. Are you entitled to Medicare based on:

   ___ Age ___ Disability ___ End Stage Renal Disease

6. Are you currently employed?

   ___No ___Yes

   Place of employment _____

   Address for Employment_____

7. Are you retired?

   ___No ___Yes

   Date of retirement: _____

8. Is your spouse currently employed?

   ___No ___Yes

9. Are they retired?

   ___No ___Yes

   Date of retirement: _____

10. Do you have group health plan Group Health Coverage based on your own, or a spouse's, current employment?

    ___No ___Yes

11. Does the employer that sponsors your Group Health Plan employ 20 or more employees?

    ___No ___Yes

I confirm that the above information is correct.

Patient Signature: _____ Date: _____

Please Print Name: _____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #_____ Date: _____

This questionnaire has been 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 that 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 that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

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 one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- ☐ My social life is normal and gives me no 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 very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- ☐ 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. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing 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 items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light 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 only 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 headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 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 care 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 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 = _____

QUICK DASH

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERELY DIFFICULTY	UNABLE TO DO
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (i.e., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (i.e., golf, hammering, tennis etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE TO DO
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week (circle number).

	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH IT PREVENTS SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand (circle one)?	1	2	3	4	5

Since the beginning of therapy my condition has improved:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

During the past 24 hours, my maximum pain rating was:

0 1 2 3 4 5 6 7 8 9 10

This section to be completed by your Physical Therapist/Provider
A Quick DASH score may not be calculated if there is greater than 1 missing item.

QUICK DASH DISABILITY SYMPTOM SCORE

$$\frac{(\text{sum of n response})}{n} - 1 \times 25$$

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80

Shoulder Pain and Disability Index

Please place a mark on the line that best represents your experience during the last week attributable to your shoulder problem.

Pain scale

How severe is your pain?

Circle the number that best describes your pain where: **0** = no pain and **10** = the worst pain imaginable.

At its worst?	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10

Total pain score _____ /50 x 100 = _____ %

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 40)

Disability scale

How much difficulty do you have?

Circle the number that best describes your experience where: **0** = no difficulty and **10** = so difficult it requires help

Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
Washing your back?	0	1	2	3	4	5	6	7	8	9	10
Putting on an undershirt or jumper?	0	1	2	3	4	5	6	7	8	9	10
Putting on a shirt that buttons down the front?	0	1	2	3	4	5	6	7	8	9	10
Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10
Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Carrying a heavy object of 10 pounds (4.5 kilograms)	0	1	2	3	4	5	6	7	8	9	10
Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10

Total disability score: _____/ 80 x 100 =_____ %

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 70)

Total Spadi score: _____ 130 x 100 = _____ %

(Note: If a person does not answer all questions divide by the total possible score, eg if 1 question missed divide by 120)

Minimum Detectable Change (90% confidence) = 13 points
(Change less than this may be attributable to measurement error)

Source: Roach et al. (1991). Development of a shoulder pain and disability index.

Cancellation/No-Show Policy

We respectfully request that if you must cancel an appointment, please call us 24 hours in advance or you will be subject to a **$25.00** cancellation fee. If appointments are not kept, your treatment program may be terminated after the second no-show or third cancellation. This will be documented in your medical record and forwarded to your physician.