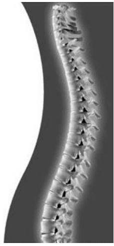

Paul W. McDonough, M.D., PA

Orthopedic Associates of Abilene

Fellowship Trained Spine Surgeon
Board certified –*American Board of Orthopaedic Surgeons*

1888 Antilley Rd Office 325-795-0225
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SPINE PATIENT INFORMATION

Name:____ Date: ____________________________

Address:____ Social Security : ___________________

City:______________________ State:______ Zip:______________ Home Phone: ______________________

Age: ____________ Sex: [ ] M [ ] F Date of Birth: ______________________

Patient's employer: __________________________________ Work Phone : ______________________

Employer address: ___________________________________ Cell Phone: ________________________

Spouse's name: ______________________________________ Employer:___________________________

Are you covered under another persons insurance? (example: spouse, parent, etc.)

Insured's name (if other than patient): ___________________________ Insured's social security:______________

Insured's address:__________________________________ Relationship to patient: ______________________

Insured's date of birth _______________

In the event of a medical emergency, whom would you like us to notify?

Name:_________________________________ Relationship:________________ Phone:______________________

Were you referred by your physician? [ ] Yes [ ] No Should we send him/her a report? [ ] Yes [ ] No

Your physician's name:____

Physician's address: ____

Symptoms

What brings you to see us today? ____

How long have you had this problem? ____

Was there an injury involved? [ ] Yes [ ] No Date: _____________ [ ] At work [ ] Auto accident

Previous back or neck surgery? [ ]Yes [ ]No

Year_____________ Type ____

Year_____________ Type ____

Which pain is worse? [ ] Back [ ] Leg [ ] Back and leg equal ______

[ ] Neck [ ] Arm [ ] Neck and arm equal______

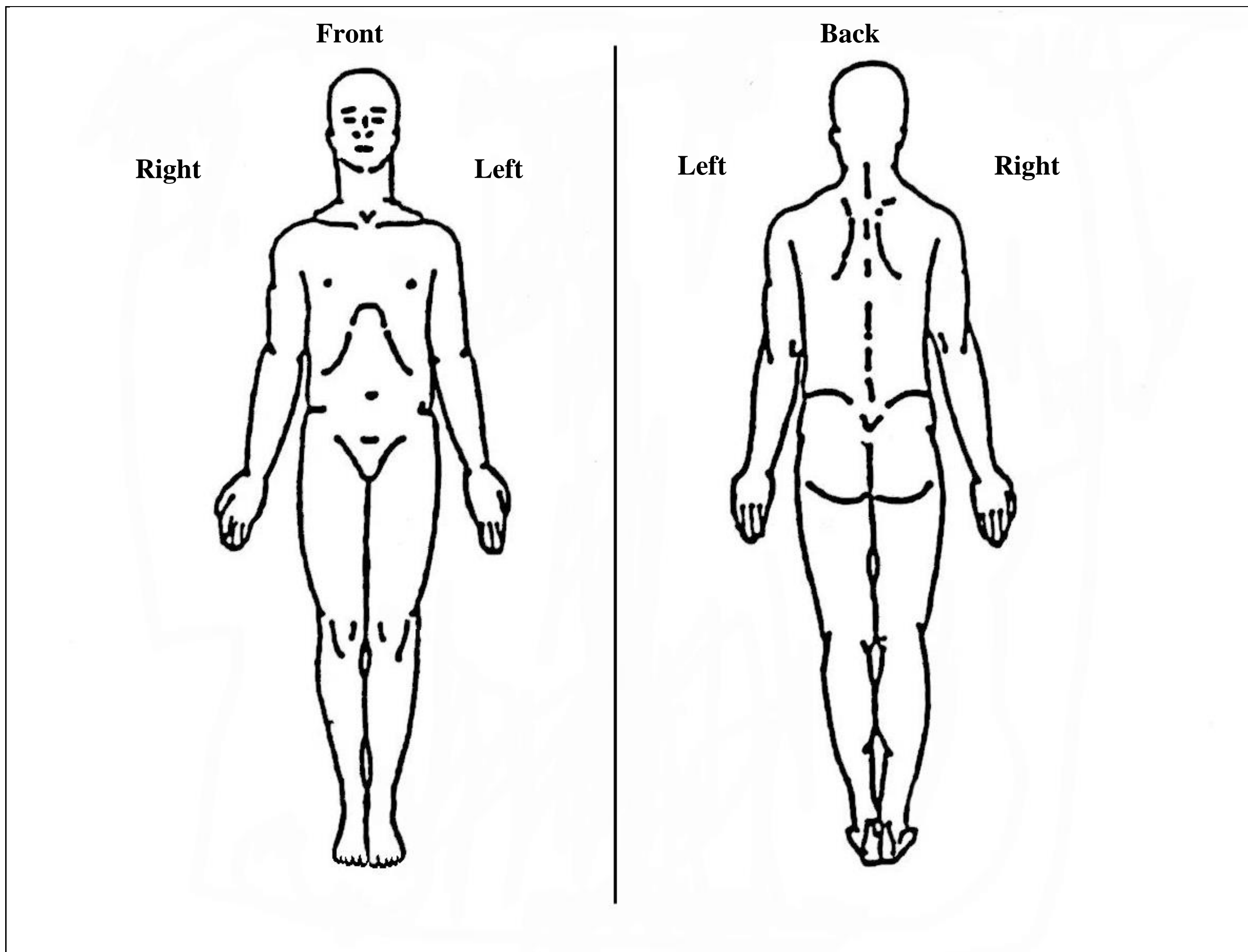
Circle your least and greatest **pain levels** over the last 2 weeks:

(None) 0----1----2----3----4----5----6----7----8----9----10 (Severe)

Mark in the areas of your body that you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below:

Pain = XXXXX Numbness = OOOOO



Which of the following activities **increase** your leg or back pain? (*Check all that apply*)

[ ] Bending [ ] Lifting [ ] Walking [ ] Standing [ ] Sitting [ ] Lying [ ] Coughing

How far can you walk before you need to stop because of leg or back pain?

[ ] Less than 1 block [ ] 1 block [ ] 2 blocks [ ] 3 blocks [ ] 4+ blocks

Is your pain decreased by rest or sitting? [ ] Yes [ ] No

What else decreases your pain? ____

What **Treatment** have you had?	Having this treatment made things: Better	Worse	No change
[ ] Physical therapy	_____	_____	_____
[ ] Injections	_____	_____	_____
[ ] Brace	_____	_____	_____
[ ] Pain medications	_____	_____	_____
[ ] Traction	_____	_____	_____

Are you currently receiving any type of financial compensation for your back problem? [ ]Yes [ ]No

Do you have an attorney for your back problem? [ ]Yes [ ]No

Medical History:

In general, your health is (mark one): [ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Terrible

Have you ever had?

[ ] Asthma/ Breathing problems
[ ] Diabetes (years_____)
[ ] Cancer (Type______________)
[ ] AIDS or tested positive for HIV
[ ] Heart attack/ Heart Disease
[ ] Hepatitis
[ ] Fibromyalgia
[ ] Gall bladder disease
[ ] Phlebitis or blood clots
[ ] Stroke
[ ] Bleed or bruise easily
[ ] Ulcer
[ ] Rheumatoid arthritis
[ ] High blood pressure
[ ] Reaction to anesthetics
[ ] High cholesterol
[ ] Kidney stones
[ ] Tuberculosis
[ ] Seizures
[ ] Migraines
[ ] Alcoholism
[ ] Thyroid disease
[ ] Anemia
[ ] Pacemaker

Other:____

____

Please list all major **Surgeries**: (include month and year)

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

Medicines: List all medications you are currently taking (prescription and non-prescription)

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

Allergies or reactions to medications or other substances

Medicine/substance Reaction (example: penicillin-rash)

____

____

Family History

			Explain:
Spinal Problems	[ ] Yes	[ ] No	______________________
Bleeding Disorders	[ ] Yes	[ ] No	______________________
Cardiac Disease	[ ] Yes	[ ] No	______________________

Social History

Marital Status: [ ] Single [ ] Married [ ] Remarried [ ] Divorced [ ] Separated [ ]Widowed

How many years? ________

Work status: [ ] Working [ ] Not working [ ] Disabled [ ] Retired [ ] Student

Primary Occupation: ____

How long have you worked at your present job: ________ If not working, last date worked: ____________

Number of children:______________ Ages: __________________________

Spouse's occupation: ____

Do you smoke? [ ] Yes [ ]No Packs per day________ Years________ Quit [ ] Yes : Year _______

Do you Drink Alcohol? [ ] Yes [ ] No Number of drinks per week_________ Wine [ ] Beer [ ] Liquor [ ]

Have you used recreational drugs? [ ] Yes [ ] No

Review of systems:

During the past year have you had? Explain:

[ ] Night sweats ______________________________
[ ] Unplanned weight loss ______________________________
[ ] Loss of appetite ______________________________
[ ] Excessive fatigue ______________________________
[ ] Depression ______________________________
[ ] Difficulty sleeping ______________________________
[ ] Unusual stress in home life ______________________________
[ ] Unexplained fevers ______________________________
[ ] Unusual stress in work life ______________________________
[ ] Easy bruising ______________________________
[ ] Excessive bleeding ______________________________
[ ] Lumps in neck, groin, armpits ______________________________
[ ] Persistent or unusual cough ______________________________
[ ] Trouble breathing with exercise ______________________________
[ ] Trouble breathing lying flat ______________________________
[ ] Coughing up blood ______________________________
[ ] Swollen ankles ______________________________
[ ] Persistent diarrhea ______________________________
[ ] Excessive constipation ______________________________
[ ] Dark black stools ______________________________
[ ] Blood in stools ______________________________
[ ] Pain or burning with urinating ______________________________
[ ] Difficulty urinating (starting, stopping) ______________________________
[ ] Blood in urine ______________________________
[ ] Generalized morning stiffness ______________________________
[ ] Dry eyes or mouth ______________________________
[ ] Skin rashes ______________________________
[ ] Joint pain or swelling ______________________________

What do you hope to gain from your visit today?

____

____

____

Physician Use: Reviewed

Date: ____________________

Sig: ____________________

Office Financial Policy

Basic Policy: Payment for services are due in full at the time services are provided. We accept cash, check, or credit card.

Please present your insurance and/or Medicare cards to be photocopied when you check in. If the telephone number of the insurance company is not on the card, please provide the number to the receptionist.

Insurance/Medicare: As a courtesy, we will bill your insurance company or Medicare for you. All co-payments and deductibles are due at the time of service.

Referrals: If your insurance carrier or health plan requires a referral from your primary care physician, you will be responsible for making sure a valid referral has been obtained. Without this referral, your insurance carrier will not cover your office visit and you will be responsible for payment.

All medical records are the property of Orthopedic Associates of Abilene L.L.P. This includes x-rays. If x-rays need to be taken from this office for any reason, we will need 10 days notice in order to mail them to their destination. If x-rays are needed before that time, we can overnight them at the patient's expense. There are also times when x-rays need to be copied before they are taken out of the office. This will also be at the patient's expense.

The physicians at Orthopedic Associates of Abilene, L.L.P. do not accept cases where there is litigation and/or attorney involved. If your circumstances fall under this category, you will be responsible for your bill and must inform the receptionist immediately.

The patient is ultimately responsible for the payment of all professional fees. I understand that I may responsible for services rendered, including reasonable attorney's fees and cost incurred in the event of any default. The information provided on this form is complete and accurate to the best of my knowledge. I have read, understood, and agree to the above financial policy for payment of professional fees.

Signature:____ **Date:** ______________________________

Release of information

I hereby authorize my physician at Orthopedic Associates of Abilene L.L.P. to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the insurance, Medicare, or any other health plan or its agents, any information needed to determine these benefits or the benefits payable to related services. Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right to privacy may be compromised.

Signature:____ **Date:** ______________________________

Assignment of insurance benefits

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at Orthopedic Associates of Abilene L.L.P. This assignment of benefits allows our office to collect directly from your insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether of not paid by said insurance.

Signature:____ **Date:** ______________________________

Acknowledgement of Review of
Notice of Privacy Practices

We will provide a copy of this office's Notice of Privacy Practices, at the time of your visit upon request which in accordance with HIPPA regulations explains how your medical information will be used and disclosed. Your signature below states that you understand your rights.

____

Signature of Patient or Personal Representative

____

Printed Name of Patient

____

Date

The Revised Oswestry Low Back and Neck Pain Questionnaire

Name:____ Date: _____/_____/______

Please Read:

This questionnaire has been designed to give your 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 best describes your condition today.**

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition.

Section 1 – Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights 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 walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can it 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 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Office use: Score_________ _________%Disability