T. Craig Derian, M.D., P.L.L.C.

Adult Reconstructive Spine Surgery

New Patient Information

In order to establish your patient medical and billing record, we require the following information from you. Fill out each space with complete and accurate information. Please print legibly.

Patient Information

Name _____
Last First Middle

Address _____
Street Apt. # P.O. Box

_____
City State Zip

Email Address _____

Phone Home ( ) _____ Leave Message Y N

Phone Cell ( ) _____ Leave Message Y N

Phone Work ( ) _____ Leave Message Y N

Date of Birth _____ **Social Security Number** _____

Sex (Circle One) **M** **F** Marital Status (Circle One) **S** **M** **D** **W**

Employer _____

Employer Address _____
Street Suite # P.O. Box

_____
City State Zip

Employer Phone ( ) _____

Family Physician _____ Physician Phone ( ) _____

Emergency Contact _____ Relationship _____

Phone ( ) _____

Who referred you to Dr. Derian? _____

We need each of these signed to be able to best manage your protected health information and assure you receive the best care. It will also allow us to bill for services rendered.

Release of Medical Information/Authorization

I hereby authorize T. Craig Derian, M.D., P.L.L.C. to release any information acquired in the course of my examination or treatment to the insurance company. This authorization shall remain valid until revoked in writing.

_____

Signature (Insured) Date

Assignment of Benefits/Authorization

I hereby authorize payment directly to T. Craig Derian, M.D., P.L.L.C. of the surgical, medical and/or major medical benefits, if any, otherwise payable to me for professional services rendered in the course of any examination or treatment. This authorization shall remain valid until revoked in writing.

_____

Signature (Insured) Date

Responsibility for Payment of Medical Services

I understand that T. Craig Derian, M.D., P.L.L.C. will file my insurance as a courtesy and will make reasonable attempts to collect from the carrier. However, I fully understand and acknowledge that I am ultimately responsible for all medical fees relating to my care. Should my insurance deny payment for any reason, I understand that I will be fully and completely responsible for my bill.

_____

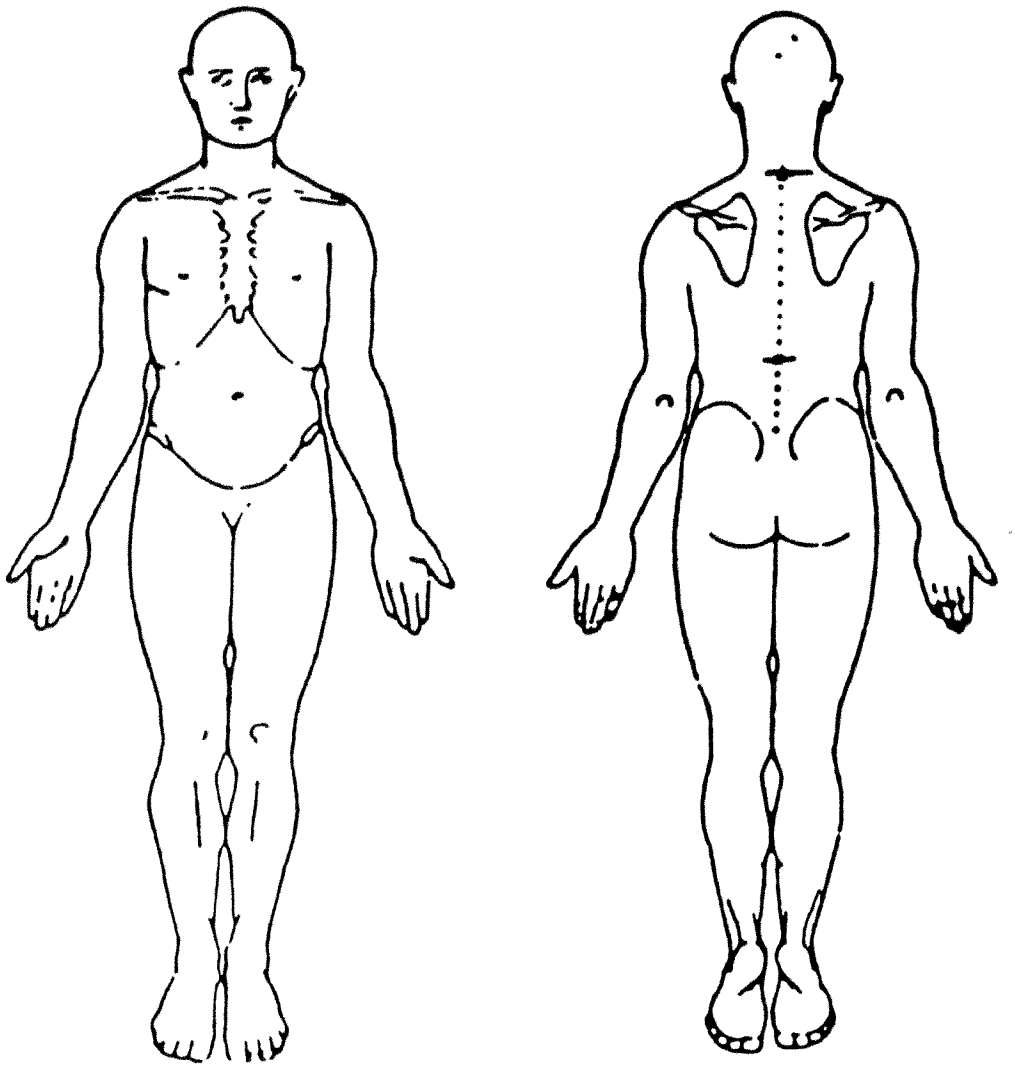
Signature (Patient or Responsible Party) Date

Please complete the diagram and bring with you for your first appointment.

Show the location of your pain, numbness or weakness on the diagram below with the following marks

NUMBNESS xxx PAIN ooo WEAKNESS vvv

Please make any additional comments on the back of this sheet.



Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back 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 without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers 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, I 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, for example 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 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 one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter 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 one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

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 extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ 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 well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – 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.
☐ 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 9 – 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 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204