DALLAS SPINE CARE
CLINICAL AND SURGICAL TREATMENT OF THE SPINE
9080 Harry Hines Blvd #210 DALLAS, TX 75235
214 .688.0078 • FACSIMILE 214.688.0359
WWW.DALLASSPINECARE.COM

ROBERT J. HENDERSON, M.D., FACS

Today's Date: _____

PATIENT NAME

Last: _____ First: _____ M: _____ Date of Birth: _____ Sex: _____

Social Security Number: _____ Language: _____ Ethnicity: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone (____) _____

Mobile: (____) _____ Email: _____

CURRENT EMPLOYER

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone (____) _____ Work Fax: (____) _____

Initial Date of Injury: _____ Type of Injury: Work: _____ Auto: _____ Other: _____

PRIVATE INSURANCE (BRING COPY OF CARD)

Carrier (Name of Insurance Company): _____

Insured's Name (if other than self): _____ Relationship: _____

Insured's Social Security Number: _____ Date of Birth: _____

SECONDARY INSURANCE (BRING COPY OF CARD)

Carrier (Name of Insurance Company): _____

Insured's Name (if other than self): _____ Relationship: _____

Insured's Social Security Number: _____ Date of Birth: _____

For Work-Related Injury

EMPLOYER AT THE TIME OF INJURY

Occupation: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone (____) _____

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EMERGENCY CONTACT (Nearest relative outside your home)

Name: _____

Relationship to Patient: _____

Best contact #: (____) _____

REFERRING SOURCE

Name: _____

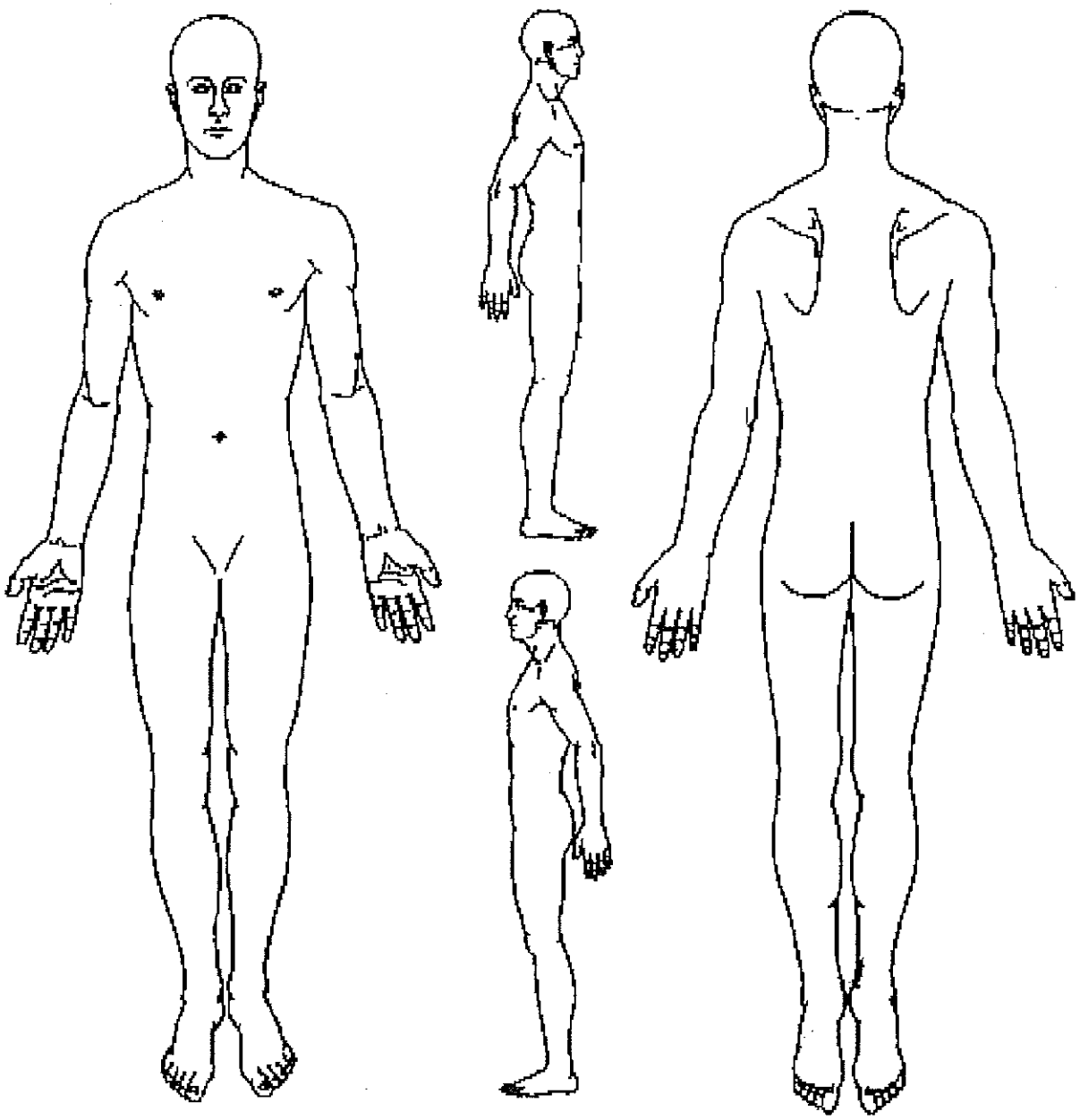
Phone (____) _____

Physician: ___ Attorney: ____ Insurance Co.: ___ Another Patient: ___ Friend: ___: Other (please specify): _____

PAIN DIAGRAM

NAME _____ DATE _____

On the diagram below, please indicate where you are experiencing pain.



On a scale of 1 to 10 with 1 being no pain and 10 being intolerable pain, indicate your pain level.

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HISTORY OF PRESENT CONDITION

1. When did your present pain begin? _____ / _____ / _____
2. Briefly, please give the details of your present condition (How did you get hurt?):

_____

_____

_____

_____

_____

3. Circle the area(s) that was initially painful.
   a. Low back
   b. Left leg
   c. Right leg
   d. Both legs
   e. Mid back
   f. Upper back
   g. Unknown

4. If the symptoms of your present pain have changed, please circle the most appropriate statement:
   a. My symptoms have remained the same since it began
   b. My symptoms are more severe since it began
   c. My symptoms are less severe since it began

   Please explain:

_____

_____

CURRENT PAIN PROFILE

5. Think of your pain in specific body parts, then assign a value to the intensity of that pain (0 is no pain and 10 is the worst) when it is at its greatest and when it is at its least. If your pain comes and goes, then 0 has to be the lowest number. Then, day in and day out, what number would you say is average?

	Lowest	Highest	Average
a. Low back	_____	_____	_____
b. Right leg	_____	_____	_____
c. Left leg	_____	_____	_____
d. Mid back	_____	_____	_____
e. Upper back	_____	_____	_____

6. In terms of characteristics, define the nature of your pain in each body part including distribution of the pain (i.e. sharp, dull, burning, throbbing, numbness, tingling, "from the hip to the big toe" or "focused to the right of midline", etc.)
   a. Low back _____
   b. Right leg _____
   c. Left leg _____
   d. Mid back _____
   e. Upper back _____

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7. Circle any areas of weakness:
   a. Ankle/foot _____
   b. Knee _____
   c. Hip _____
   d. Low back _____
   e. Mid back _____
   f. Upper back _____

   Indicate location using the following (Place corresponding # in the blank provided):
   1. Right
   2. Left
   3. Right and left
   4. Midline

8. Please rate your average pain intensity 0 – 10 in the following situations:

a. Sitting	0	1	2	3	4	5	6	7	8	9	10
b. Standing	0	1	2	3	4	5	6	7	8	9	10
c. Walking	0	1	2	3	4	5	6	7	8	9	10
d. In a car	0	1	2	3	4	5	6	7	8	9	10
e. In the morning	0	1	2	3	4	5	6	7	8	9	10
f. Midday	0	1	2	3	4	5	6	7	8	9	10
g. Evening	0	1	2	3	4	5	6	7	8	9	10
h. Night time	0	1	2	3	4	5	6	7	8	9	10

9. Regarding your ability to function, please identify the maximum amount of time you can (in stationary positions, shifting is allowable):
   a. Sit in a straight-back chair _____
   b. Stand _____
   c. Walk _____
   d. Ride/drive in a car _____

10. Describe your most comfortable position:
    _____
    _____

11. Which of the following activities changes the nature of your pain:

	Aggravates pain (makes it better)	Relieves pain (makes it worse)
a. Sitting	_____	_____
b. Standing	_____	_____
c. Rising from sitting	_____	_____
d. Going from standing to sitting	_____	_____
e. Leaning forward (i.e., brushing teeth)	_____	_____
f. Walking	_____	_____
g. Lying on your side	_____	_____
h. Lying on your back	_____	_____
i. Driving	_____	_____
j. Coughing/Sneezing/Laughing	_____	_____
k. Bending forward (i.e., to pick something up)	_____	_____

    Now go back and put an asterisk (*) next to the worst activity and the best activity

12. Do you exercise? Y N
    a. If yes, how many days per week? _____
    b. How much time do you spend per exercise session on average? _____
    c. Name some of the exercises you are doing in a typical routine? _____
       _____
       _____

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13. Are there any activities that have gotten less or stopped because of your pain? Y N
    a. If yes, please describe: _____

PAST BACK HISTORY

14. Have you had any other episodes of back and/or leg pain not related to your current problem? Briefly explain:

15. Have you ever had surgery on your spine? Y N
    a. If yes, please provide the report for each operation. If you do not have the reports, we need your consent to obtain them ASAP.

16. Have you ever had an injection for your spine? Y N
    a. If yes, please provide the report for each injection. If you do not have the reports, we need your consent to obtain them ASAP.

17. Have you ever had supervised physical therapy and/or chiropractic care for your spine? If yes, where, what did you do and for how long? Please explain briefly:

18. Have you been trained in any of the following therapeutic techniques (Place a check mark next to all that apply)?
    a. Core stabilization _____
    b. McKenzie exercises _____
    c. Williams flexion program _____
    d. Stretching _____
    e. Strengthening _____
    f. Cryotherapy _____

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19. Using the following list of treatments, please indicate the effect of those which have been used in an attempt to heal your present injury:

	Helpful	Not Helpful	How long did it help?
a. Supervised PT			
b. Chiropractic			
c. Acupuncture			
d. Pain management (meds)			
e. Epidural Steroid Injection			
f. Facet Joint Injection			
g. Ultrasound			
h. Traction			
i. Gravity Traction (inversion)			
j. Core Stabilization			
k. TENS unit			
l. Cold packs			
m. Hot packs			

20. Please indicate with a checkmark if you have had any of the following studies:
    a. Plain Films _____
    b. MRI _____
    c. CT _____
    d. Myelogram _____
    e. Discogram _____
    f. EMG/NCV _____

21. List any known drug allergies/adverse reactions:

_____ _____
_____ _____
_____ _____

CURRENT MEDICATIONS

22. Please list your current medications. Begin with pain medications. Also include over-the-counter meds and supplements:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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MEDICAL, SOCIAL AND VOCATIONAL HISTORY

23. Place a check mark next to the most appropriate answer:
    a. Married ___ d. Single ___
    b. Widowed ___ e. Divorced ___
    c. Separated ___

24. Are you a cigarette smoker, dip snuff, chew tobacco (use nicotine)? Y N
    a. If yes, how much do you use per day? _____

25. Are you an ex-nicotine user? Y N
    a. If yes, then how much and for how long? _____

26. Do you drink alcoholic beverages? Y N
    a. If yes, how much do you drink? _____

27. History of substance abuse (prescribed and/or recreational)? Y N

28. Please list your known medical conditions (ex: High blood pressure, cancer, diabetes, etc):

    _____ _____ _____
    _____ _____ _____
    _____ _____ _____

29. Please list your family's known medical conditions (ex: High blood pressure, cancer, diabetes, etc). Indicate maternal, paternal and/or sibling:

    _____ _____ _____
    _____ _____ _____
    _____ _____ _____

30. Do you have any difficulty with urination? Y N
    a. If yes, please explain: _____

31. Do you have any difficulty evacuating your bowels? Y N
    a. If yes, please explain: _____

32. Do you have any problems with sexual organ function? Y N
    a. If yes, please explain: _____

33. Do you participate in sexual relations: Y N
    a. If yes, does this activity aggravate your pain? Y N
        i. During > after ___
        ii. After > during ___
        iii. During = after ___

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REVIEW OF SYSTEMS

Childhood Diseases (Circle those that you have had)

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Small Pox	yes	no	Rheumatic Fever	yes	no	Whooping cough	yes	no
Tuberculosis	yes	no	Scarlet Fever	yes	no	Chicken pox	yes	no

Circle items that you have had or currently had. For common illnesses, circle only if you consider it to be abnormal for you.

Neurological

Blackouts	yes	no	Seizures	yes	no	Migraine headache	yes	no
Concussion	yes	no	Hit in head	yes	no	Lymes Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke	yes	no	Difficulty Walking	yes	no
Blurred vision	yes	no	Double Vision	yes	no			

Cardiovascular

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass surgery	yes	no
Hypertension	yes	no	Hypotension	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	AICD	yes	no
Mononucleosis	yes	no	Easy bruising	yes	no	Mitral Valve Prolapse	yes	no
Poor circulation	yes	no						

Respiratory

Hayfever	yes	no	Bronchitis	yes	no	Lung surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short breath	yes	no						
Tuberculosis	yes	no						

Gastro-Intestinal

Reflux	yes	no	Nausea	yes	no	Persistent vomiting	yes	no
Diarrhea	yes	no	Hiatal hernia	yes	no	Lactose intolerance	yes	no
Constipation	yes	no	Peptic Ulcer	yes	no	Vomiting blood	yes	no
Diabetes	yes	no	Hepatitis A B C D	yes	no			

Genito-Urinary

			Discharge	yes	no	Painful urination	yes	no
Incontinence	yes	no	Bladder infections	yes	no	Venereal disease	yes	no
Frequency	yes	no	Blood in urine	yes	no	Kidney disease	yes	no
Urgency	yes	no	Hemorrhoids	yes	no			

Other

Difficulty hearing	yes	no	Thyroid disease	yes	no	Weight Gain		
Cataracts	yes	no	Atherosclerosis	yes	no	Unexplained	yes	no
Arthritis	yes	no	Cancer	yes	no	Glaucoma	yes	no
Sinus trouble	yes	no	Hernia R or L	yes	no	Organ transplant	yes	no
Blood transfusion (when_____)			Weight loss			Back trouble	yes	no
Hives or Eczema	yes	no	Unexplained	yes	no	Unexplained rash	yes	no
AIDS	yes	no						

Other Health Condition(s) Not Listed: _____

Name: _____	Date:	_____	Page 1 of 3
☐ Pre-OP	Factor: I:	_____ %	Daily Activities
☐ 3 Month Post-OP	Factor II:	_____ %	Work/Leisure Activities
☐ 6 Month Post-OP	Factor III:	_____ %	Anxiety/Depression
☐ 12 Month Post-OP	Factor IV:	_____ %	Social Interest
☐ 24 Month Post-OP			

DALLAS PAIN QUESTIONNAIRE

Please read: This questionnaire has been designed to give your doctor information as to how your pain has affected your life. Be sure these are your answers. Do not ask someone else to fill out the questionnaire for you. **Please mark an "X" along the line that expresses your thoughts, from 0 to 100, in each section.**

SECTION I: PAIN AND INTENSITY – To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None 0% — some — All the time 100%

(; ; ; ; ;)

0 1 2 3 4 5

SECTION II: PERSONAL CARE - How much does your pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)?

None, (no pain) 0% — some — I cannot get out of bed 100%

(; ; ; ;)

0 1 2 3 4

SECTION III: LIFTING - How much limitation do you notice in lifting?

None (I can lift as I did) 0% — some — I cannot lift anything 100%

(; ; ; ; ;)

0 1 2 3 4 5

SECTION IV: WALKING - Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same 0% — some — I cannot walk 100%

(; ; ; ; ;)

0 1 2 3 4 5

SECTION V: SITTING - Back pain limits my sitting in a chair to:

No pain, same as before 0% — some — I cannot sit at all 100%

(; ; ; ; ;)

0 1 2 3 4 5

SECTION VI: STANDING - How much does your pain interfere with your tolerance to stand for long periods?

None, same as before 0% — some — I cannot stand 100%

(; ; ; ; ;)

0 1 2 3 4 5

SECTION VII: SLEEPING - How much does your pain interfere with your sleeping?

None, same as before 0% — some — I cannot sleep at all 100%

(; ; ; ;)
0 1 2 3 4

D... _____ x 3 = _____%

SECTION VIII: SOCIAL LIFE - How much does your pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None, same as before 0% — some — No activities Total loss 100%

(; ; ; ; ; ; ;)
0 1 2 3 4 5 6 7

SECTION IX: TRAVELING - How much does your pain interfere with traveling in a car?

None, same as before 0% — some — I cannot travel 100%

(; ; ; ; ; ;)
0 1 2 3 4 5 6

SECTION X: VOCATIONAL - How much does your pain interfere with your job?

None, no interference 0% — some — I cannot work 100%

(; ; ; ; ; ; ;)
0 1 2 3 4 5 6 7

W... _____ x 5 = _____ %

SECTION XI: ANXIETY/MOOD - How much control do you feel you have over demands made on you?

(No change) Total 100% — some — None 0%

(; ; ; ; ; ;)
0 1 2 3 4 5 6

SECTION XII: EMOTIONAL CONTROL - How much control do you feel you have over your emotions?

(No change) Total 100% — some — None 0%

(; ; ; ; ; ; ;)
0 1 2 3 4 5 6 7

SECTION XIII: DEPRESSION - How depressed have you been since the onset of pain?

Not depressed significnatly 0% — some — Overwhelmed by depression 100%

(; ; ; ; ; ; ;)

0 1 2 3 4 5 6 7

A... _____ x 5 = _____ %

SECTION XIV: INTERPERSONAL RELATIONSHIPS - How much do you think your pain has changed your relationships with others?

Not changed 0% — some — Drastically changed 100%

(; ; ; ; ; ; ;)

0 1 2 3 4 5 6 7

SECTION XV: SOCIAL SUPPORT - How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)?

None needed 0% — some — All the time 100%

(; ; ; ; ; ;)

0 1 2 3 4 5 6

SECTION XVI: PUNISHING RESPONSE - How much do you think others express irritation, frustration or anger toward you because of your pain?

None 0% — some — All the time 100%

(; ; ; ; ; ; ;)

0 1 2 3 4 5 6 7

S... _____ x 5 = _____ %

Name: _____ Date: _____

☐ Pre-OP ☐ 3 Month Post-OP

☐ 6 Month Post-OP ☐ 12 Month Post-OP

☐ 24 Month Post-OP TOTAL SCORE: _____ %

OSWESTRY

Please read: This questionnaire has been designed to give the doctor/clinician information as to how your back pain has affected your ability to manage in every day life. Please answer every section, and mark in each section only the ONE sentence that applies to you. We realize you may consider that two of the statements in any one section may relate to you, but please just mark the sentence that 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 my 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 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 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 ½ 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 for 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 at all.
- ☐ 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 me no extra pain.
- ☐ My sex life is normal but causes me 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 affect 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.