DATE: _____ HOME PHONE: _____

NAME OF PATIENT: _____

(Last name) (First name) (Middle)

RESPONSIBLE PARTY (if a minor):_____

STREET ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

SEX: _____Male ____Female AGE: ____ BIRTHDATE: _____ MARITAL STATUS: _____

PATIENT EMPLOYED BY: _____

BUSINESS ADDRESS: _____

OCCUPATION: _____ BUSINESS PHONE: _____

SPOUSE (or responsible party) EMPLOYED BY: _____

BUSINESS ADDRESS: _____

OCCUPATION: _____ BUSINESS PHONE: _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

SOCIAL SECURITY (Patient) #:_____ SPOUSE SOCIAL SECURITY #:_____

DO YOU HAVE MEDICAL INSURANCE? _____ No___ Yes If Yes, (PRIMARY)

NAME OF COMPANY: _____ NAME OF SUBSCRIBER: _____

GROUP OR ACCOUNT #:_____ I.D. #: _____

INS. CO. ADDRESS: _____

ANY OTHER MEDICAL INSURANCE? _____No_____ Yes If Yes, (SECONDARY)

NAME OF COMPANY: _____ NAME OF SUBSCRIBER: _____

GROUP OR ACCOUNT #:_____ I.D. #: _____

INS. CO. ADDRESS: _____

In case of emergency, who should be notified? _____ PHONE: _____

REFERRING DOCTOR: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

ALLERGIES: _____

YOUR DRUGSTORE/PHARMACY NAME**:** _____ PHONE**:** _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING**:** _____

(Name)	(Dose)	(Frequency)
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHIEF COMPLAINT: (purpose of your visit, when and how did your problem begin?)

_____

_____

_____

_____

PREVIOUS HOSPITALIZATIONS: (Please include all previous surgeries/operations)

(Date)	(Reason)
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU OR DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF THE FOLLOWING:

Seizures	No_____ Yes_____	If Yes, Who? _____
High Blood Pressure	No_____ Yes_____	If Yes, Who? _____
Stroke	No_____ Yes_____	If Yes, Who? _____
Heart Disease	No_____ Yes_____	If Yes, Who? _____
Arthritis	No_____ Yes_____	If Yes, Who? _____
Diabetes	No_____ Yes_____	If Yes, Who? _____
Cancer	No_____ Yes_____	If Yes, Who? _____
Tuberculosis	No_____ Yes_____	If Yes, Who? _____
Bleeding Disorders	No_____ Yes_____	If Yes, Who? _____
Hepatitis	No_____ Yes_____	If Yes, Who? _____
Other	No_____ Yes_____	If Yes, Who? _____
DO YOU SMOKE?	No _____ Yes_____	If Yes, how much? _____
DO YOU DRINK ALCOHOL?	No _____ Yes_____	If Yes, how much? _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

_____ DATE _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO NEUROSURGERY CONSULTANTS P.A.

_____ DATE _____

****

COMPLETE THIS SECTION IF WORKERS COMP OR AUTO ACCIDENT RELATED

DATE OF ACCIDENT_____

ATTORNEY NAME AND PHONE NUMBER: _____

_____

TYPE OF ACCIDENT MOTOR VEHICLE WORKERS COMP OTHER

BODY PART(S) INJURED_____

INSURANCE COMP NAME, ADDRESS AND PHONE NUMBER

_____

_____

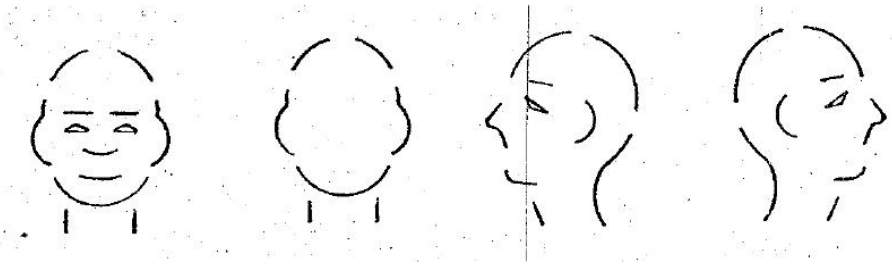
_____

_____

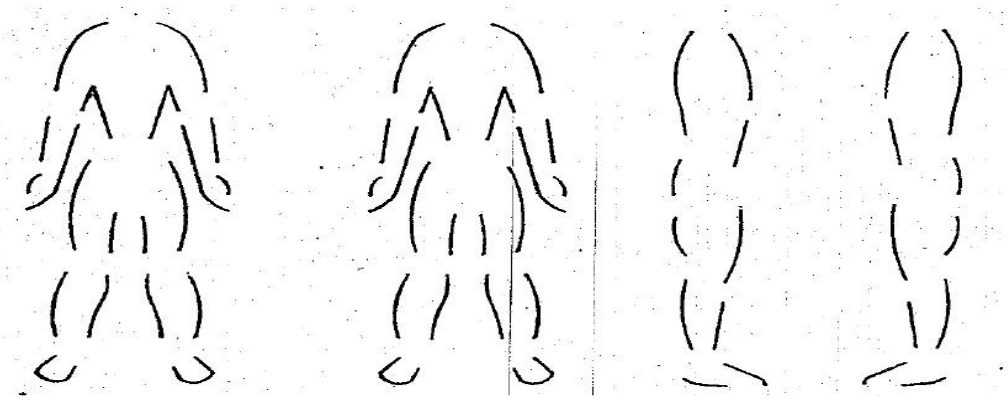
_____

Name: _____ **Date:** _____

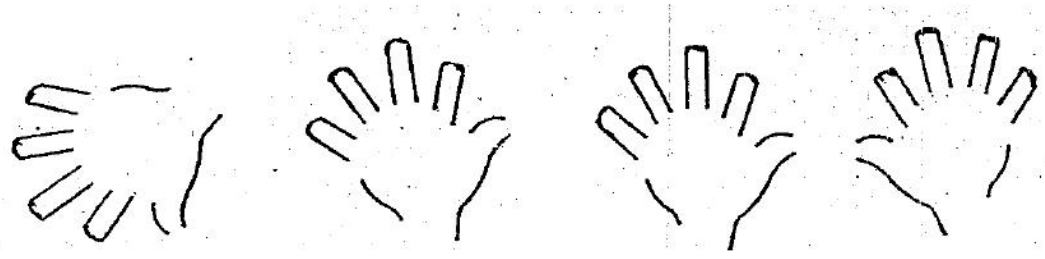
Using the figures below please indicate where your pain is by drawing on the figures.



Front of Head Back of Head Left of Head Right Side



Front of body Back of body Right side Left side



Right hand Palm Down Right hand Palm Up Left hand Palm Down Left hand Palm Up

PAIN SCALE

1 (MILD)

2

3

4

5

6

7

8

9

10 (MAX)

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name**:**_____ Date**: ……..**

Please Read:

This questionnaire has designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, & mark in each section only the ONE box 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 box which closely describes your problem:

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 (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 & 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 & stay in bed.

Section 3-Lifting

- ☐ I can lift heavy weights without 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 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- Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5- Headaches

□ I have no headaches at all.

□ I have slight headaches, which come infrequently.

□ I have moderate headaches, which comes infrequently.

□ I have moderate headaches, which come frequently.

□ I have severe headaches, which come infrequently.

□ I have headaches almost all the time.

Section 6 -Concentration

□ I can concentrate fully when I want to with no difficulty.

□ I can concentrate fully when I want to with slight difficulty.

□ I have a fair degree of difficulty in concentrating when I want to.

□ I have a lot of difficulty in concentrating when I want to.

□ I have a great deal of difficulty in concentrating when I want to.

□ I cannot concentrate at all.

Section 7-Work

□ I can do as much work as I want to.

□ I can only do my usual work but no more.

□ I can do most of my usual work, but no more.

□ I cannot do my usual work.

□ I can hardly do any work at all.

□ I cannot do any work at all.

Section 8- Driving

□ I can drive my car without any neck pain.

□ I can drive my car as long as I want with slight pain in my neck.

□ I can drive my car as long as I want with moderate pain in my neck

□ I cannot drive my car as long as I want because of moderate pain in my neck.

□ I can hardly drive at all because of severe pain in my neck.

□ I cannot drive my car at all.

Section 9 - Sleeping

□ I have no trouble sleeping

□ My sleep is slightly disturbed (less than 1 hour sleepless)

□ My sleep is mildly disturbed (l-2 hours sleepless)

□ My sleep is moderately disturbed (2-3 hours sleepless)

□ My sleep is greatly disturbed (3-5 hours sleepless)

□ My sleep is completely disturbed (5-7 hour sleepless)

Section 10- Recreation

□ I am able to engage in all of my recreational activities with no neck pain at all.

□ I am able to engage in all of my recreational activities with some pain in my neck.

□ I am able to engage in most, but not all of my recreational activities because of pain in my neck.

□ I am able to engage in a few of my recreational activities because of pain in my neck.

□ I can hardly do any recreational activities because of pain in my neck.

□ I cannot do any recreational activities at all.

DISABILITY SCORE: TOTAL SCORE-_____/50

Oswestry Low Back Pain Disability Questionnaire, continued

*Outcomes Instruments are included here as samples and are not for reproduction. For information about obtaining an these Instruments from their original sources, please refer to individual reviews in the **Compendium.***

Oswestry Disability Index 2.0
Patient name**:** _____ File**#** _____Date**:**_____

Please read instructions:

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely describes you today.

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 (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 & 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 & stay in bed.

Section 3 –Lifting

- ☐ I can lift heavy weights without 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 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 left or carry anything at all.

Section 6 – Standing

- ☐ I can stand as long as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevent me from standing for more than 1 hour.
- ☐ Pain prevent me from standing for more than ½ hours.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours of sleep.
- ☐ Because of pain, I have less than 4 hours of sleep.
- ☐ Because of pain, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 –Sex Life (if applicable)

- ☐ 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 4- Walking

□ Pain does not prevent me walking any distance.

□ Pain prevents me walking more than 1 mile.

□ Pain prevents me walking more than ¼ of a mile.

□ Pain prevents me walking more than 100 yards.

□ I can only walking using 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 sit in my favorite chair as long as I like.

□ Pain prevents me from sitting for more than ½ hour.

□ Pain prevents me from sitting for more than ½ hour.

□ Pain prevents me from sitting more than 10 minutes.

□ Pain prevents me from sitting at all.

Section 9- Social Life

□ My social life is normal and causes 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., sports, 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 but it gives 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 receive treatment.

	Bikash Bose, M.D.	
	SF-12 Health Survey	**PID: _____**

Patient Last Name	**First Name**

Evaluation Interval	**Evaluation Date**	
☐ Preop ☐ 1 Week Postop (1-7 days) ☐ 1 Month Postop (8 -45 days) ☐ 2 Months Postop (46 -.75 days) ☐ 3 Months Postop (76 -100 day) ☐ 6 Months Postop (106-195 days) ☐ Other (> 195 days) (specify):_____	____/____/____ MM / DD / YY	

Instructions: This survey asks for your view about your health. This information will help track how you feel and how well you are able to do your usual activities. Answer each question by checking one box. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health in?	Excellent	Very good	Good	Fair	Poor
	☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities such as moving a table, pushing a vacuum, blowing or playing golf	☐	☐	☐
3. Climbing several flights of stairs	☐	☐	☐

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	Yes	No
4. Accomplished less than you would like	☐	☐
5. Were limited in the kind of work or other activities	☐	☐

Please turn this form over and complete questions on the other side.

During the past four weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?	Yes	No
6 Accomplished less than you would like	☐	☐
7. Didn't do work or other activities as carefully as usual	☐	☐

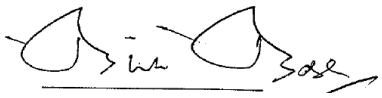
8. During the past four weeks, how much did Pain interfere with your normal work (including both work outside the home and housework)?	Not at all	A little bit	Moderately	Quite a bit	Extremely
	☐	☐	☐	☐	☐

These questions are able how you feel and how things have been with you during the last four weeks. For each question, please give the one answer that comes closed to the way you have been feeling.						
How much of the time during the last four Weeks**....**	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	☐	☐	☐	☐	☐

Prescription Policy

All requests for prescription refills must be made with 48 hours or 2 business days advance notice due to the surgical schedule. **Absolutely no narcotics or controlled substances will be filled after regular office hours or on weekends or holidays or by other on-call physicians.** Please plan ahead by calling the office by 3PM Mon thru Thurs and by 12 Noon on Fridays. Lost or stolen prescriptions cannot be replaced. Neurosurgery Consultants, P.A. is primarily a surgical practice. If surgery is not an option for you, or if you choose not to have surgery, you will be referred to another appropriate provider to further assist you. This may be your family doctor or pain management specialist. We do not provide chronic pain management. Postoperatively, we will work with you to decrease or eliminate your use of narcotics as soon as possible. Prolonged use of narcotics and muscle relaxants is detrimental to good health.



Bikash Bose, M.D.

_____ _____

Patient acknowledgement Date

Neurosurgery Consultants P.A

Patient Privacy Policy
Acknowledgement form

I hereby acknowledge that I have received and had an

Opportunity to ask questions concerning Neurosurgery

Consultants, P.A.'s notice of patient privacy policy

_____ _____

Patient or Patient's Representative ***Date***

_____

Representative's Relationship to Patient