**PATIENT REGISTRATION FORM** **PATIENT # _____**

Name: _____ M.I._____ ☐ Female ☐ Male

Address:_____

City: _____ State:_____Zip:_____ E-mail address:_____

Home #_____Cell #_____Work #_____

Emergency Contact, Relation & Phone #_____

Date of Birth: Mo_____Day_____Yr_____ SS#:_____-_____-_____

Complaint:_____

**Treating Doctor:**_____ Phone: _____

**Type of Accident**

☐ Auto Accident
☐ Slip/Fall
☐ Workers Comp

**Attorney Information**

Attorney: _____

Firm: _____

Phone #: _____

Address: _____

**Date of Injury:**

Mo_____Day_____Yr_____

In **Which State** did the Accident Occur?____

**Employer Information:** (WORKER'S COMP Cases Must Fill Out)

Employer: _____ Phone #: _____

Address: _____

City:_____ State: _____ Zip:_____

**Motor Vehicle/Worker's Compensation Insurance:** **Policy Holder:** _____

Insurance:_____

Address_____Phone _____

City:_____State:___Zip:_____ Adj:_____

Policy #:_____ Claim #_____

Do you have personal health insurance: ☐ Yes ☐ No

**Signature:** _____**Date:**_____

**Eastern PA Orthopedics**
**255 S. 17th St., 30th Fl. Philadelphia, PA 19103**
**215-735-5911** **Fax: 215-735-5914**

# AUTHORIZATION BY PATIENT

I, _____, hereby authorize and direct_____

to furnish to EASTERN PENNSYLVANIA ORTHOPEDIC ASSOCIATES complete copies of all records, reports, notes, x-rays, bills, facts and information in your possession pertaining to my injuries, physical condition and disability as a result of an accident occurring on _____. A copy of the Authorization may be used in lieu of my original signature.

Sensitive information

| **AIDS/HIV** | **Psychiatric Care/Treatment** | **Treatment for Drug or Alcohol use/abuse** |
|---|---|---|
| ☐ **Yes, Disclose** | ☐ **Yes, Disclose** | ☐ **Yes, Disclose** |
| ☐ **No, Do not Disclose** | ☐ **No, Do not Disclose** | ☐ **No, Do not Disclose** |

_____
Date of Birth

X_____
Patient's Signature

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# HIPPA PATIENT PRIVACY RIGHTS

I, _____, have received and read the HIPPA Patient Privacy Rights.
Patient's Name

X_____
Patient's Signature

**ACCIDENT QUESTIONNAIRE**

**Name**: _____ **Age**:_____

1. **Date of Accident:**_____

2. **Were you hurt**? Please list any complaints:

_____
_____
_____

3. **Type of Accident**

Bicycle
Bus
Car
Motorcycle
Other:_____**(If OTHER skip to # 6)**
Assault/Pedestrian/Slip & Fall

4. **Were you hit from**: Front Rear Driver's side Passenger's side

5. When accident occurred **what did you hit**? (Example: head hit dashboard, arm hit window, etc.)

_____

6. Did you **hit your head**? Yes No

7. Did you **lose consciousness**? Yes No

8. Were you **cut or bruised**? Yes No

9. Did you **go to the hospital**? Yes No

If yes, Name of Hospital:_____
Were you taken by ambulance? Yes No
Did you stay overnight? Yes No
Did you receive treatment such as medications, a cast, surgery? Yes No
Please describe:_____

10. Have you had any **diagnostic studies done**?

| | |
|---|---|
| **MRI of:** | What Facility? |
| **X-Ray of**: | What Facility? |
| **CT-SCAN of:** | What Facility? |
| **EMG of:** | What Facility? |
| **Other test:** | What Facility? |

11. Have you had **any treatment** such as chiropractics, aquatic therapy, pain management?

**Name of Doctor** **Specialty/Length of treatment**

_____

_____

_____

12. Since the accident, **have your symptoms**:

Improved a lot Improved a little Stayed the same Become worse

13. If you were **employed at the time of the accident**, did you **miss work**? Yes No

14. Have you ever had a **similar accident**? _____

If yes, date: _____

Describe injuries: _____

15. Are you **taking medications** now? Yes No

If yes, please list: _____

_____

16. Please list any **medications you are allergic to**:_____

17. Please describe any **serious illnesses**: _____

_____

18. Have you ever **had surgery**? Yes No

If yes, what **type of surgery**? _____

19. What is your **height**: _____

20. What is your **weight**: _____lbs

**Circle the pain severity level**

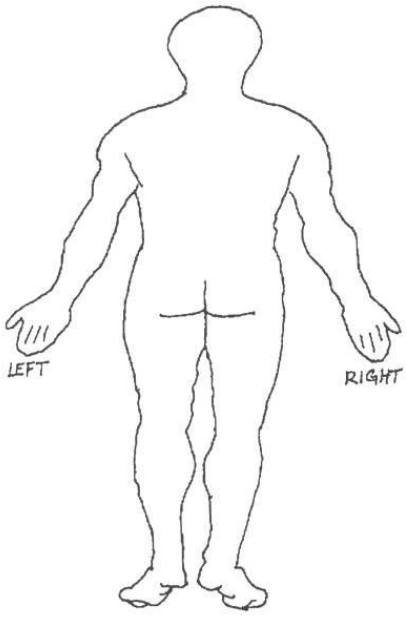
| Pain Severity Level | None<br>0<br>No Pain | Mild<br>1 2 3<br>Annoying pain | Moderate<br>4 5 6 7<br>Pain causes you to slow down. | Severe<br>8 9 10<br>Pain levels must limit your ability to perform some activities. |
|---|---|---|---|---|
| Effect | | Aware of discomfort Able to do activities. | Takes longer to complete work. May be unable to do demanding work. | Inability to do certain activities. Must have some difficulty sleeping. |
| Feeling | | Dull soreness ache, stiffness. | Hurting pain, very sore, limited motion | Sharp pain, stabbing or jabbing pain. |

# **ONLY MARK THE PARTS OF YOUR BODY**
# THAT YOU HURT IN THE ACCIDENT

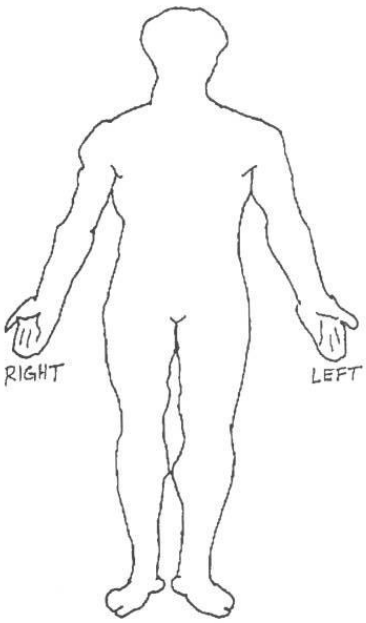
Using the symbols given below, *mark the areas on the figure* that corresponds to the areas on your body where you feel the described sensations. Please include all affected areas. Note that there is a left and right and a front and back. Just to complete the picture, please draw in your face.

| Aching | Numbness | Pins & Needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| ΔΔΔΔ | NNNN | ***** | XXXX | /////// | TTTT |

Back




Front




Pain in arm(s) compared with neck: [ ] worse [ ] same [ ] less
Pain in leg(s) compared with back: [ ] worse [ ] same [ ] less

Name: _____ Date: _____

# Owestry Low Back Pain Scale

Name: _____ Date_____

Please rate the severity of your pain by circling a number below:

*No pain* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Instructions: Please circle the ONE NUMBER in each section which most closely describes your problem.

**Section 1 – Pain Intensity**

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

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

0 I would not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increase the pain but I mange not to change my way of doing it.
3 Washing and dressing increases the pain and find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing and dressing with out help.
5 Because of the pain I am unable to do any washing and dressing without help.

**Section 3 – Lifting**

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, ex: on a table.
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights at most.

**Sections 4 – Walking**

0 I have no pain on walking.
1 I have some pain on walking, but it does not increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than ½ mile without increasing pain.
4 I cannot walk more than ¼ mile without increasing pain.
5 I cannot walk at all without increasing pain.

**Sections 5 – Sitting**

0 I can sit in any chair as long as I like.
1 I can sit only in my favorite chair as long as I like.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than ½ hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain immediately.

**Section 6 – Standing**

0 I can stand as long as I want without pain.
1 I have some pain in standing but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than ½ hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain immediately.

**Sections 7 – Sleeping**

0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of pain my normal nights sleep is reduced by less than one-quarter.
3 Because of pain my normal nights sleep is reduced by less than one-half.
4 Because of pain my normal nights sleep is reduced by less than three-quarters.
5 Pain prevents me from sleeping at all.

**Sections 8 – Social Life**

0 My social life is normal and gives me no pain.
1 My social life is normal but increases the degree of pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, ex: dancing
3 Pain has restricted my social life and I do no go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

**Section 9 – Traveling**

0 I get no pain when traveling.
1 I get some pain when traveling but none of my usual forms of travel make it worse.
2 I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3 I get extra pain while traveling which compels me to seek alternative forms of travel.
4 Pain restricts me to short necessary journeys under ½ hour.
5 Pain restricts all forms of travel.

**Section 10 – Changing Degree of Pain**

0 My pain is rapidly getting better.
1 My pain fluctuates but is definitely getting better.
2 My pain seems to be getting better but improvement is slow.
3 My pain is neither getting better or worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

TOTAL : _____

**NECK DISABILITY INDEX**

**Name**: _____

**Date**: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE number 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**

0 I have no pain at the moment.
1 The pain is very mild at the moment.
2 The pain is moderate at the moment.
3 This pain is fairly severe at the moment.
4 The pain is very severe at the moment.
5 The pain is the worst imaginable at the moment.

**Section 2- PERSONAL CARE (Washing, Dressing, etc.)**

0 I can look after myself normally, without causing extra pain.
1 I can look after myself normally, but it causes extra pain.
2 It is painful to look after myself and I am slow and careful.
3 I need some help, but manage most of my personal care.
4 I need help every day in most aspects of care.
5 I do not get dressed; I wash with difficulty and stay in bed.

**Section 3- LIFTING**

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights, but it gives extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (for example, on a table.)
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4 I can lift very light weights.
5 I cannot lift or carry anything at all.

**Section 4- READING**

0 I can read as much as I want to, with no pain in my neck.
1 I can read as much as I want to, with slight pain in my neck.
2 I can read as much as I want to, with moderate pain in my neck.
3 I **can't** read as much as I want, because of moderate pain in my neck.
4 I can hardly read at all, because of severe pain in my neck.
5 I cannot read at all.

**Section 5- HEADACHES**

0 I no headaches at all.
1 I have slight headaches that come infrequently.
2 I have moderate headaches that come infrequently.
3 I have moderate headaches that come frequently.
4 I have severe headaches that come frequently.
5 I have headaches almost all the time.

**SECTION 6- CONCENTRATION**

0 I can concentrate fully when I want to, with no difficulty.
1 I can concentrate fully when I want to, with slight difficulty.
2 I have a fair degree of difficulty in concentrating when I want to.
3 I have a lot of difficulty in concentrating when I want to.
4 I have a great deal of difficulty concentrating when I want to.
5 I cannot concentrate at all.

**SECTION 7- WORK**

0 I can do as much work as I want to.
1 I can do my usual work, but no more.
2 I can do most of my usual work, but no more.
3 I cannot do my usual work.
4 I can hardly do any work.
5 I can't do any work at all.

**SECTION 8- DRIVING**

0 I can drive my car without any neck pain.
1 I can drive my car as long as I want, with slight pain in my neck.
2 I can drive my car as long as I want, with moderate pain in my neck.
3 I **can't** drive my car as long as I want, because of moderate pain in my neck.
4 I can hardly drive at all, because of severe pain in my neck.
5 I **can't** drive my car at all.

**SECTION 9- SLEEPING**

0 I have no trouble sleeping.
1 My sleep is slightly disturbed (less than 1 hr sleepless)
2 My sleep is mildly disturbed (1-2 hrs sleepless)
3 My sleep is moderately disturbed (2-3 hrs sleepless)
4 My sleep is greatly disturbed (3-5 hrs sleepless)
5 My sleep is completely disturbed (5-7 hrs sleepless)

**SECTION 10- RECREATION**

0 I am able to engage in all my recreation activities, with no neck pain at all.
1 I am able to engage in all my recreation activities, with some neck pain.
2 I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3 I am able to engage in few of my recreation activities because of pain in my neck.
4 I can hardly do any recreation activities, because of pain in my neck.
5 I **can't** do any recreation activities at all.

Total : _____