



MCNEIL ORTHOPEDICS, INC.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: M  F  Left  or Right  Handed?  
 Height: \_\_\_\_\_ ft \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs Date of Injury \_\_\_\_\_  
 Reason for visit: \_\_\_\_\_ Are you Pregnant? Y  N   
 Have you had X-rays for this problem? Y  N  If yes, where were they done? \_\_\_\_\_

Is this a Worker's Comp Injury? Y  N  Auto Accident Injury? Y  N  Is this a legal case? Y  N

**"This ENTIRE form should be COMPLETELY filled out!"**

**USE OF TOBACCO:**  Smoke every day  Some days  Quit  Never Smoked

**MARITAL STATUS:**  Married  Single  Widow  Divorced  Other  
**EMPLOYMENT:**  Occupation \_\_\_\_\_  Unemployed  Retired  Disabled  Student  
**USE OF ALCOHOL:**  Never  Rarely  Moderate  Daily  Quit  
 Drinks per day \_\_\_\_\_ Use of any other recreational drugs not listed above? \_\_\_\_\_

On a scale from 0 (no pain) to 10 (worst possible pain), how would you rate your pain today? \_\_\_\_\_  
 Have you had your flu shot?  Yes  No If yes, when? \_\_\_\_\_  
 Have you had your pneumococcal vaccine?  Yes  No If yes, when? \_\_\_\_\_

**Please indicate (X) current and/or past conditions you have had:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Polio
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Arthritis/Rheumatoid	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Frequent Heartburn/Reflux Disorder	<input type="checkbox"/> Stroke/Paralysis
<input type="checkbox"/> Back/Neck Pain	<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other
<input type="checkbox"/> Crohn's/Colitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> No Significant Medical History
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Cancer: Type _____	

Do you have any previous history of DVT/blood clots  Yes  No Do you have a metal allergy?  Yes  No  
 Do you have any stents?  Yes  No Do you have an advanced care directive?  Yes  No  
 Do you have a pacemaker?  Yes  No

**Please list all you prior SURGERIES:**

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cancer Surgery	<input type="checkbox"/> Elbow Surgery
<input type="checkbox"/> Gallbladder Surgery	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> ACL
<input type="checkbox"/> Hernia	<input type="checkbox"/> Ankle Surgery	<input type="checkbox"/> Carpal Tunnel Surgery
<input type="checkbox"/> Cardiac Bypass	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> Back/Spine Surgery
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Knee Arthroscopy	<input type="checkbox"/> Other
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Shoulder Arthroscopy	<input type="checkbox"/> No Past Surgery
<input type="checkbox"/> Vascular Surgery	<input type="checkbox"/> Hip Replacement	

**Please indicate (X) major medical problems that your FAMILY MEMBERS (alive or deceased) have had:**

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Elevated Cholesterol
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> No Significant Family History
<input type="checkbox"/> PE	<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Gout	<input type="checkbox"/> Neurological Disorders	

Please list all medications and dosages (mg) you currently take:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Preferred Pharmacy & Location: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Patient's Signature: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

**1. Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

**MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT**

**1. Pain Intensity**

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

**2. Personal Care (washing, dressing, etc.)**

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

**3. Lifting**

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

**4. Walking**

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 1/2 mile.
- (3) Pain prevents me from walking more than 1/4 mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

**5. Sitting**

- (0) I can sit in any chair as long as I like.
- (1) I can only sit 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 1/2 hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

**6. Standing**

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

**7. Sleeping**

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

**8. Social Life**

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

**9. Traveling**

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

**10. Employment / Homemaking**

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg. lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only		
Comorbidities:	<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas	<input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____

PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

**LEFS – INITIAL VISIT**

**Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

	<u>Extreme Difficulty or Unable to Perform Activity</u>	<u>Quite a Bit of Difficulty</u>	<u>Moderate Difficulty</u>	<u>A Little Bit of Difficulty</u>	<u>No Difficulty</u>
1. Any of your usual work, housework or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Getting into or out of the bath	0	1	2	3	4
4. Walking between rooms	0	1	2	3	4
5. Putting on your shoes or socks	0	1	2	3	4
6. Squatting	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor	0	1	2	3	4
8. Performing light activities around your home	0	1	2	3	4
9. Performing heavy activities around your home	0	1	2	3	4
10. Getting into or out of a car	0	1	2	3	4
11. Walking 2 blocks	0	1	2	3	4
12. Walking a mile	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs)	0	1	2	3	4
14. Standing for 1 hour	0	1	2	3	4
15. Sitting for 1 hour	0	1	2	3	4
16. Running on even ground	0	1	2	3	4
17. Running on uneven ground	0	1	2	3	4
18. Making sharp turns while running fast	0	1	2	3	4
19. Hopping	0	1	2	3	4
20. Rolling over in bed	0	1	2	3	4

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.

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PATIENT NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE: \_\_\_\_\_

**Description:** This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

**1. Please rate your pain level with activity:** NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

**NECK DISABILITY INDEX – INITIAL VISIT**

**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) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worse imaginable at the moment.

**2. Personal Care (washing, dressing, etc)**

- (0) I can look after myself normally without 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 self care.
- (5) I cannot get dressed, wash with difficulty and stay in bed

**3. Lifting**

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

**4. Headache**

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

**5. Recreation**

- (0) I am able engage in all my recreational activities without pain.
- (1) I am able to engage in my recreational activities with some pain.
- (2) I am able to engage in most but not all of my usual recreational activities because of my neck pain.
- (3) I am able to engage in a few of my usual recreational activities with some neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I can't do any recreational activities at all.

**6. Reading**

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

**7. Work**

- (0) I can do as much as I want to.
- (1) I can only 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 usual work at all.
- (5) I can't do any work at all.

**8. Sleeping**

- (0) Pain does not prevent me from sleeping well.
- (1) My sleep is slightly disturbed (<1 hr sleep loss).
- (2) My sleep is mildly disturbed (1-2 hr sleep loss).
- (3) My sleep is moderately disturbed (2-3 hr sleep loss).
- (4) My sleep is greatly disturbed (3-4 hr sleep loss).
- (5) My sleep is completely disturbed (5-7 hr sleep loss).

**9. Concentration**

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

**10. Driving**

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

*Neck Disability Index © Vernon H. and Mior S., 1991.*

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	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity
	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Surgery for this Problem
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
	<input type="checkbox"/> Multiple Treatment Areas	
<b>ICD Code:</b> _____		

QuickDASH - Initial

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS**

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

**1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5
	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NONE	MILD	MODERATE	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

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