Dr. Stanley C. Jones
7500 Beechnut #150
Houston, TX 77074

Spine Care

Date: ______________________

I. GENERAL INFORMATION:

Name ______________________________ Age ________ Male Female
Dominant Hand: _____ Left _____ Right Height ______ Weight ______
Marital Status: Single Married Divorced Widowed
Referred By: ____________________________

RACE/ETHNIC GROUP (please circle):
African American Caucasian Hispanic Asian American Indian Other ________________

WORKING STATUS:
Presently Employed: Y / N
Full-Time Part-Time Light Duty Disabled Housewife Retired
Occupation___________________________________

II. REVIEW OF SYSTEMS

Have you ever had back surgery? Yes No
When was your last physical examination? _________________________ More than 5 yrs ago
Do you have any **DRUG ALLERGIES?** Yes No
If YES, please list: ____
Have you ever had any of the following conditions? (Circle all that apply)

Previous Blood Transfusions
Headaches not relieved by medication
Colitis
Migraine Headaches
Episodes of Frequent Urination
Difficult or Painful Urination
Hepatitis
Difficulty Breathing
Diabetes
Asthma
Seizures
Previous surgeries *(please list)*
____
____
____

Cancer
Heart Disease
HIV
High Blood Pressure
Stroke
Blood Clots in the Legs
Psoriasis
Excessive Fatigue
Stomach Ulcers
Frequent Episodes of Constipation
Depression

I have not had any of the above conditions _____________ (Initial Here).

III. PAST, SOCIAL & FAMILY HISTORY

Do you SMOKE? Yes No #packs per day ________ # years smoking __________
(Cigarettes, Cigars, Pipe, Chew Tobacco)
Do you drink ALCOHOL? Yes No #drinks per day ______ #per week _____ #years drinking_____

Do you have a FAMILY HISTORY of any of the following *(please mark):*

	Mother / Father	Grandmother / Grandfather
Cancer	______ / _______	_________ / __________
Diabetes	______ / _______	_________ / __________
Heart disease	______ / _______	_________ / __________
Rheumatoid Arthritis	______ / _______	_________ / __________
Arthritis	______ / _______	_________ / __________
Stroke	______ / _______	_________ / __________

IV. PRIOR EVALUATION

PLEASE LIST THE NAME OF ANY PHYSICIAN/FACILITY YOU HAVE BEEN TO FOR YOUR CURRENT PROBLEM:

____
____
____
____

Name:_____________________________________ **Date:** ____________________

Have you had any of the following prior treatments for the *CURRENT* problem?

Physical Therapy	Massage Therapy	Medication	Chiropractic Treatments
Acupuncture	Epidural Injection (s)	Steroid Injection (s)	

Please list any prior BACK OR NECK surgeries you have had:

SPINE SURGERY	**PROCEDURE**	**LEVELS**	**DATE**
List levels and dates	Lumbar Disc Surgery	________	_________
	Lumbar Fusion	________	_________
	Other: _______________	________	_________

Please list any medication that you are currently taking

____
____
____
____

V. CHIEF COMPLAINT

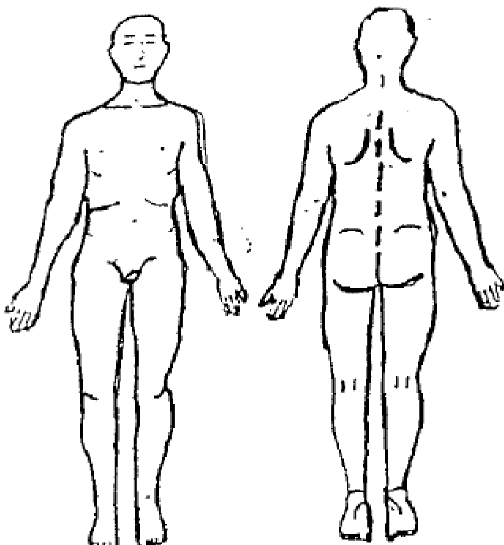
Please give a detailed description of how the pain began: ______________________________________

____
____
____
____
____
____
____
____
____

Is there anything that you do that makes you feel better? *(Please describe*)

____
____
____
____

Please place an X on the areas below where you have pain



Visual Analog Pain Scale: Check the level of **BACK** pain today.
(0 = none 10 = unbearable)

0 1 2 3 4 5 6 7 8 9 10

Visual Analog Pain Scale: Check the level of **LEG** pain today.
(0 = none 10 = unbearable)

0 1 2 3 4 5 6 7 8 9 10

I have reviewed the current symptomatology, review of systems and past medical, family, and social history.

____

Stanley C. Jones, M.D.

SF-36® Health Survey

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor

2. ***Compared to one year ago***, how would you rate your health in general ***now****?*

Much better	Somewhat better now	About the same	Somewhat worse	Much worse now

3. 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
a. **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing **several** flights of stairs	1	2	3
e. Climbing **one** flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking **more than a mile**	1	2	3
h. Walking **several blocks**	1	2	3
i. Walking **one block**	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the ***past 4 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
a. Cut down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Were limited in the **kind** of work or other activities	1	2
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the ***past 4 weeks***, have you had any of the following problems with your work or other regular daily activities ***as a result of any emotional problems*** (such as feeling depressed or anxious)?

	Yes	No
a. Cut down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Didn't do work or other activities as **carefully** as usual	1	2

6. During the ***past 4 weeks***, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely

7. How much ***bodily*** pain have you had during the *past 4 weeks*?

None	Very mild	Mild	Moderate	Severe	Very severe

8. During the ***past 4 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

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the ***past 4 weeks***...

	All of the time	Most of the time	A Good Bit of	Some of the time	A little of the time	None of the time
Did you feel full of pep?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Did you feel worn out?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired?	1	2	3	4	5	6

10. During the ***past 4 weeks***, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time

11. How TRUE or FALSE is *each* of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	1	2	3	4	5
I am as healthy as anybody I know	1	2	3	4	5
I expect my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

Oswestry Low Back Questionnaire

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 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.

Personal Care (e.g., Washing, Dressing)

- ☐ 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, I wash with difficulty, and I stay in bed.

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 (e.g., 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.

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 walk only with crutches or a cane.
- ☐ 5 I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
- ☐ 3 Pain prevents me from sitting for more than 1/2 hour.
- ☐ 4 Pain prevents me from sitting for more than 10 minutes.
- ☐ 5 Pain prevents me from sitting at all.

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 for more than 1 hour.
- ☐ 3 Pain prevents me from standing for more than 1/2 hour.
- ☐ 4 Pain prevents me from standing for more than 10 minutes.
- ☐ 5 Pain prevents me from standing at all.

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 medication, I sleep less than 6 hours.
- ☐ 3 Even when I take medication, I sleep less than 4 hours.
- ☐ 4 Even when I take medication, I sleep less than 2 hours.
- ☐ 5 Pain prevents me from sleeping at all.

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 (e.g., sports, dancing).
- ☐ 3 Pain prevents me form 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.

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 under 1/2 hour.
- ☐ 5 My pain prevents all travel except for visits to the physician / therapist or hospital.

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 (e.g., 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 home chores.

____