

CASPER ORTHOPAEDIC ASSOCIATES, PC



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Office Information

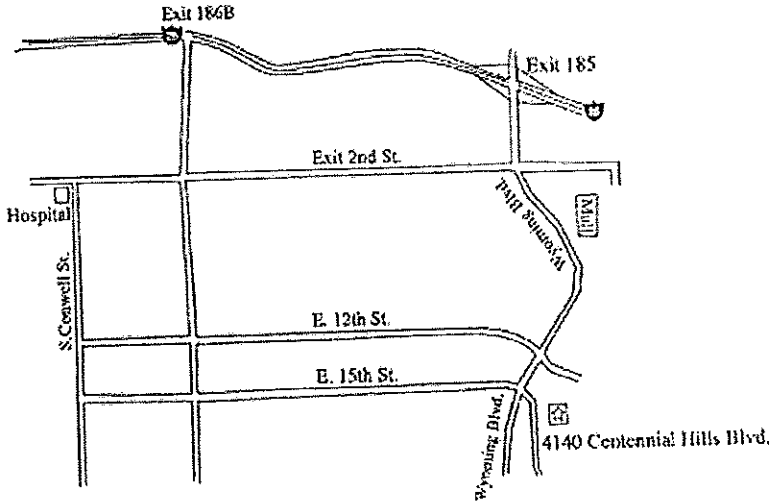
[Notice of Privacy Practices](#)

Office Location
 4140 Centennial Hills Blvd.
 Suite A
 Casper, WY 82609

T 307.265.7205
 F 307.235.6262
 Toll Free 1.888.317.2343

Office Hours
 8:00am - 5:00pm
 Monday - Friday

Insurance Information
 We file with most major insurance plans. Complete paperwork is required before filing with any insurance company.



Appointments

Appointments for routine office visits may be made during regular office hours by calling 307.265.7205 or 1.888.317.2343. Please do not call on weekends to schedule a routine appointment.

We believe your time is valuable. While we endeavor to keep scheduled appointments, sometimes on emergency occurs. We will inform you when your doctor is unable to keep the appointment or is going to be significantly delayed and we will ask your preference in rescheduling.

Forms

- [Patient Information Form](#)
- [Medical History Form](#)
- [Assignment of Insurance Benefits](#)
- [Arbitration Agreement](#)



Telephone

If you have a question or problem that needs the attention of your orthopaedic surgeon, please call during office hours. Since it is not always practical for us to interrupt the doctor during patient exams, you are asked to relay your message and/or problem to one of our staff. Your call will be answered as soon as possible, usually by the close of office hours.

After office hours, calls made to the office will automatically reach our answering service and will be directed to the physician on call.

Prescriptions & Renewals

TWENTY FOUR Hour Notification

Prescriptions and medication refills are issued during office hours only (before noon on Fridays). For a prescription refill, please call the pharmacy first and let them contact us. Please remember to check your need for medicine prior to weekends and holidays. The physician on call for the weekend will not refill

narcotic prescriptions. We ask for twenty-four-hour notification of refills/ 48 hours for narcotic medication refills.

Confidentiality (72 hour notification)

Your medical records are confidential, so it is necessary for you to sign a release before we may send information to you or to any insurance company, attorney or other parties. Before we may release any information to your attorney we must have a written request from him/her. The fee for copying records varies.

X-rays are the property of the physician who has taken them and are retained as part of the patient's medical record. You may receive copies of your x-rays that have been taken in our office for a small fee. You will be notified of that cost before copies are made.

It is very important that the office be given a 72-hour notice to prepare your copies for you.

Surgery/Precertification

If you require surgery, our office staff will assist you with the necessary paperwork and arrangements. This can be a lengthy process and we thank you for your patience. If you have any questions after leaving the office, please don't hesitate to call for clarification.

Your insurance company may require pre-certification for surgery. It is your responsibility to contact your insurance company to begin the pre-certification process if it is required. If your insurance company requires additional medical information, they will need to contact our office.

Failure to pre-certify with your insurance may result in a decreased payment and/or denial of your claim leaving you responsible for payment on all surgery charges.

Some surgical procedures require a surgical assistant. If an assistant surgeon is used, an estimate of their fee is normally 20% of the surgeon's fee.

Fees & Payments

We make every effort to decrease the cost of your medical care. Therefore, we request payment arrangements for a office services at the time they are rendered unless prior arrangements have been made. We accept cash, checks, MasterCard, and Visa, for your convenience. As a courtesy we are willing to file a claim with your insurance once we receive the completed paperwork in our office. However, payment is the patient's responsibility. Employees are available to assist you with insurance billing and other payment options. Please feel free to speak with them regarding your account.

Disability Insurance

If you have insurance which pays income, or house/car/credit card payments when you are disabled, there may be forms we need to complete. You are responsible for getting these forms to our office in adequate time for completion (7 working days). There is a charge to complete each form. If this procedure is followed, your claim will be processed quickly and as a result, you will receive your benefits in a timely manner.

[Wyoming Surgical Center, LLC](#) | [Wyoming Orthopaedic & Sports Therapy Center](#) | [Casper Orthopaedic Associates, PC](#)

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Last Modified: August 8, 2006

Privacy Policy

Casper Orthopaedic Associates, P.C. Privacy Notice – Effective November 1, 2002

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your physicians, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies, please do not hesitate to ask our privacy officer who can be reached at (307) 265-7205.

Information We Collect About You

We collect personal information about you and your family as part of our registration process, during the course of your care and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information. During the course of your treatment, we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment or routine health care operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. Casper Orthopaedic Associates, P.C. does not sell patient information. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. Casper Orthopaedic Associates, P.C. maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Casper Orthopaedic Associates, P.C.

Changes To Our Privacy Policy

All new patients will receive a copy of our privacy policy. Casper Orthopaedic Associates, P.C. occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right To Restrict Use Of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed, it will remain in effect until you request a change.

BINDING ARBITRATION STATEMENT

In an attempt to resolve any claims of malpractice fairly and quickly, Casper Orthopaedic Associates, PC and the Wyoming Surgical Center and its associates are instituting a Binding Arbitration Agreement, hereafter called "agreement." We will use this agreement to address any major concerns and claims that you may have regarding your care. The crisis in availability and cost of professional liability insurances requires us to do this.

This agreement will help you keep your physician in Wyoming. Our main goal is to take care of our patients. Recruitment and retention of physicians in Casper is a problem and will continue to be a problem in the near future.

Should a claim need to be filed, this process will allow faster handling of the claim and allow both parties to discuss the problem in a neutral atmosphere that is less antagonistic and formal than in a court of law. It should minimize the costs of claims for both the patient and the healthcare provider. It **does not** jeopardize your ability to have a concern addressed in an impartial setting.

Feel free to discuss this agreement with our office personnel; however, **we require this agreement to be signed in order to treat you.**

ARBITRATION AGREEMENT
CASPER ORTHOPAEDIC ASSOCIATES, P.C.

ARTICLE 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

ARTICLE 2 Definitions

- A. The term "we," "parties," or "us" means you, (the Patient), and the provider.
- B. The term "Claim" means one or more Malpractice Actions as defined under Wyoming law.
- C. The term "Provider" means the physician, group or Casper Orthopaedics, and their employees, partners, associates, and agents.
- D. The term "Patient" or "you" means:
 - (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents, or legal representatives.

ARTICLE 3 Dispute Resolution Options

- A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
 - (1) working directly with each other to try and find a solution that resolves the Claim, OR
 - (2) using non-binding mediation (each of us will bear one-half of the costs); OR
 - (3) using binding arbitration as described in this Agreement.

YOU MAY CHOOSE TO USE ANY OR ALL OF THESE METHODS TO RESOLVE YOUR CLAIM

- B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
- C. Arbitration – Final Resolution. If working with the Provider or using nonbinding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

ARTICLE 4 How to Arbitrate a Claim

- A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
- B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
 - (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

- (2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal court of Wyoming. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Wyoming court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Wyoming Uniform Arbitration Act.
- C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
- D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Wyoming Uniform Arbitration Act.
- E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). This includes consulting, assisting, or referral physicians utilized by Casper Orthopaedics, including, but not limited to anesthesiologists, pathologists, and other subspecialists. Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

ARTICLE 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

ARTICLE 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Casper, Wyoming. Arbitration proceedings are private and shall be kept confidential. The provisions of the Wyoming Uniform Arbitration govern this Agreement. We hereby waive the pre-litigation panel review requirements of Wyoming Statute. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

ARTICLE 7 Term / Rescission / Termination

- A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
- B. Rescission. You may rescind this Agreement within 3 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing.

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

ARTICLE 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

ARTICLE 9 Acknowledgment of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that I can rescind this Agreement within 3 (three) days of signing it.

I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

By: _____
Patient or Patient's Representative

Relationship to Patient

Print Patient's Name

Date

By: _____
Physician or Authorized Representative

CASPER ORTHOPAEDIC ASSOCIATES, P.C.

Appointment Doctor _____ Date _____

PATIENT INFORMATION (CHILDS name if applicable):

Last _____ First _____ Middle _____

*SSN _____ Age _____ Male Female

DOB _____ Marital Status _____

Street _____

City _____ State _____ Zip _____

Mailing _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

E-Mail Address _____

Employer _____ Work Status _____

Employer Address _____

Employer Phone _____ Occupation _____

RESPONSIBLE PARTY / PARENT PRESENT WITH CHILD

Last _____ First _____ Middle _____

*SSN _____ Age _____ Male Female

DOB _____ Marital Status _____

Street _____

City _____ State _____ Zip _____

Mailing _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Employer _____ Work Status _____

Employer Address _____

Employer Phone _____ Occupation _____

SPOUSE / OTHER RESPONSIBLE PARTY

Last _____ First _____ Middle _____

*SSN _____ Age _____ Male Female

DOB _____ Marital Status _____

Street _____

City _____ State _____ Zip _____

Mailing _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (C) _____

Employer _____ Work Status _____

Employer Address _____

Employer Phone _____ Occupation _____

INSURANCE 1

Ins. Co. Name _____

Insured Policy Holder _____

Insured DOB _____ SSN _____

Policy ID # _____ Group ID # _____

Relationship to Patient _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone # _____

Pre Certification Phone # _____

INSURANCE 2

Ins. Co. Name _____

Insured Policy Holder _____

Insured DOB _____ SSN _____

Policy ID # _____ Group ID # _____

Relationship to Patient _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Phone # _____

Pre Certification Phone # _____

CURRENT INJURY INFORMATION

Type: Accident Work Auto Date _____

Place _____ Time _____

Body Part: _____ Right Left Bilateral

Description of Accident _____

RELATIVE / FRIEND NOT LIVING IN HOME

Last _____ First _____

Address _____

City _____ State _____ Zip _____

Phone _____

Disclosure of this information is voluntary. However, failure to provide this information will result in no credit being extended and all services must be paid for at the time they are rendered.

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. Charges shown by statements are agreed to be correct and reasonable, unless protested in writing within thirty days of the billing date. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I authorize Casper Orthopaedic Associates, P.C. to obtain credit/employment information required for collection purposes.

X-rays taken at Casper Orthopaedic Associates, P.C. will remain the property of Casper Orthopaedic Associates, P.C. Copies of x-rays can be provided for a small fee.

It may be necessary for additional tests to be ordered and performed outside of Casper Orthopaedics Associates, P.C. I authorize transfer of medical information, patient information and insurance information to the following outside sources: Wyoming Medical Center, Casper Surgical Center, Wyoming Surgical Center, Wyoming Imaging Center, Casper Medical Imaging, Diagnostic Lab, and Medical Testing Lab and/or other medical facilities if indicated. I have the right to amend, revoke and to obtain a written report annually of all disclosures of health information.

Casper Orthopaedics will routinely call the patient to remind them of an upcoming appointment. A message will be left on your voice mail or answering machine regarding the date and the time of that appointment and / or accounting issues.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims.

Signature of Responsible Party _____ Date _____

I have received the Patient Information Brochure _____ / _____
Patient Signature Date

PRIVACY NOTIFICATION

By signing below, you acknowledge that you have been informed of the Notice of Information Privacy Practices ("Notice") from Casper Orthopaedic Associates, P.C. You have the right to review our Notice prior to signing this acknowledgment. The terms of the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Casper Orthopaedic, P.C. at (307) 265-7205 and request a revised Notice. We will also post any revised Notice at 4140 Centennial Hills Boulevard. You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to those restrictions.

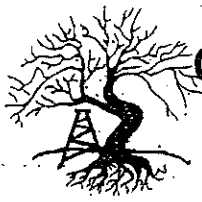
Acknowledgment _____ Date _____

INSURANCE OPTION

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Insurance 1 _____ Insurance 2 _____

Insured Policy Holder Name _____ Insured Policy Holder Name _____
(Signature) (Signature)
Date _____ Date _____



**Casper
Orthopaedics**

Sports, Spine, Bones, Joints & Trauma

4140 CENTENNIAL HILLS BLVD., SUITE A • CASPER, WYOMING 82609
PHONE (307) 265-7205 • FAX (307) 235-6262
1-888-317-2343

ASSIGNMENT OF INSURANCE BENEFITS

If you would like us to process your insurance claims, please provide us with ALL the information requested below and sign beneath the statement.

NAME OF PATIENT _____

POLICY HOLDER'S INFORMATION

NAME OF POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____

ID# _____ GROUP POLICY NUMBER _____

POLICY HOLDER'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S TELEPHONE NUMBER _____

NAME OF INSURANCE COMPANY _____

ADDRESS WHERE CLAIMS ARE SUBMITTED _____

INSURANCE COMPANY'S TELEPHONE NUMBER - _____

We will file past claims for this condition/injury from the date you were initially seen for the said injury/condition, unless a specified date is indicated. _____

I hereby authorize and request payment to be made directly to Casper Orthopaedic Associates, P.C. for medical treatment provided to myself or any member of my family covered by my medical insurance program. If necessary, I authorize release of medical information relative to any claims submitted to my insurance company. I understand that any part of my bill not paid by my insurance company is my responsibility. Further, should my insurance company not honor this assignment of benefits, I will immediately forward any payment made directly to me by my insurance carrier. This authorization shall remain in effect for twelve (12) months from the date signed. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any affect on any actions they took before they received the revocation. If in the event legal action should become necessary to collect an unpaid balance due for medical services rendered or supplies, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

SIGNATURE OF PRIMARY POLICY HOLDER _____ DATE _____

Patient Name: _____ Occupation: _____

Referring Physician: _____

Primary Care Physician: _____

ALLERGIES:

Allergy		Reaction
Latex	Yes	No
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS:

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PREVIOUS SURGERIES:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

Reviewed RN Signature: _____ Date: _____

Physician Signature: _____ Date: _____

CASPER ORTHOPAEDIC ASSOCIATES

Please fill out these forms completely!

We Know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of your and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes and fill in the blanks where indicated.

Thank you for your helping us to know you better!

Date: _____

Patient Name: _____
(Please print)

Gender: Male Female

Date of Birth: _____
Month/Day/Year

Current Age: _____

Height: _____ Weight: _____

Referring Physician: _____

Primary Care Physician: _____

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

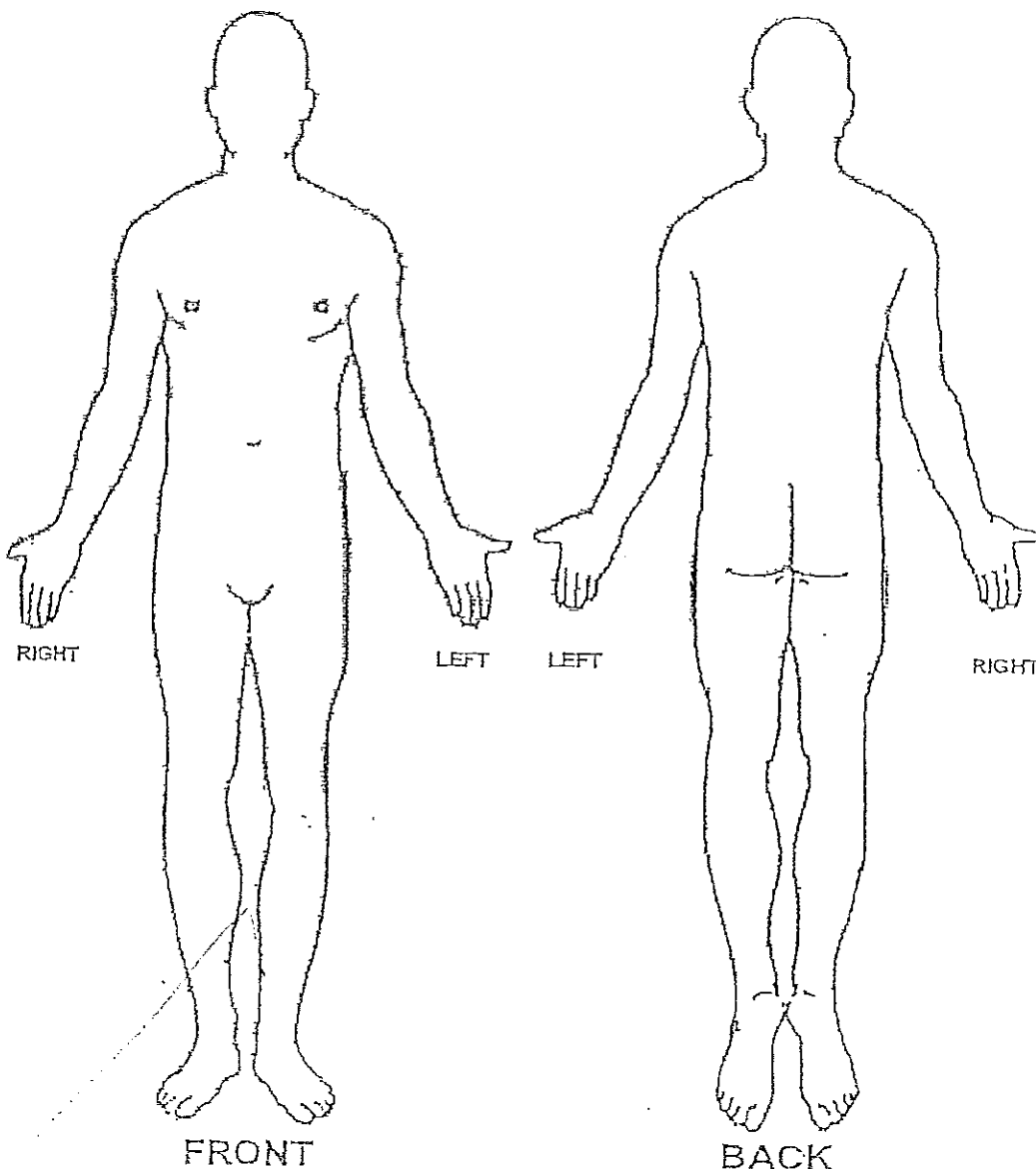
- Ache
AAAAA
AAAAA
AAAAA

- Numbness
NNNN
NNNN
NNNN

- Pins & Needles
PPPP
PPPP
PPPP

- Burning
BBBB
BBBB
BBBB

- Stabbing
SSSS
SSSS
SSSS



Casper Orthopaedic Associates

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

I don't know how it began.

It comes and goes.

I've had it a long time. (____ years)

Injury (date of injury _____) On the job? yes no
Please explain how the injury happened.

Are you currently in litigation with regards to your back pain?
yes no

Have you been laid off from your job? yes no N/A

How bad is your pain? Place an "X" (—X—) on each of the lines below to indicate your pain.

How bad is your low back pain?

No pain-----Worst possible

How bad is your leg pain?

No pain-----Worst possible

How bad is your middle back pain?

No pain-----Worst possible

How bad is your neck pain?

No pain-----Worst possible

How bad is your arm pain?

No pain-----Worst possible

Do you have any of the following problems?
(Please check your answer.)

Is your pain worse at night? yes no

Does your pain awaken you from sleep? yes no

Does coughing affect your pain? yes no

Do your legs tire/hurt if you walk too far? yes no

If YES, how far can you walk?

less than 1 block 1-3 blocks more than 3 blocks

Is this relieved by resting your legs? yes no

Is this relieved by bending forward? yes no

Bladder Control (urine):

No problem

Can't empty bladder

Loss of urine (accidents)

Bowel Control:

No problem

Constipation

Loss of control (accidents)

How does each of the following affect you pain? (check your answer)

Sitting	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Standing	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Walking	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Lying down	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Rising from chair	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Physical activity	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Heat	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know
Cold	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know
Massage	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know



PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

- | | | |
|----------------------------|---------------------------------|--------------------------------|
| Chiropractic care | <input type="checkbox"/> better | <input type="checkbox"/> worse |
| Physical therapy | <input type="checkbox"/> better | <input type="checkbox"/> worse |
| Injections | <input type="checkbox"/> better | <input type="checkbox"/> worse |
| Psychological consultation | <input type="checkbox"/> better | <input type="checkbox"/> worse |
| Other: _____ | <input type="checkbox"/> better | <input type="checkbox"/> worse |

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6 mo	<12 mo
X-rays	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV (nerve test)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had surgery on your back or neck?

yes no If YES, complete the following:

1) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

2) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

3) Type of surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better or worse?

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check

<input type="checkbox"/> Heart attack <input type="checkbox"/> Heart murmur <input type="checkbox"/> Angina <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose veins <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Duodenal problems <input type="checkbox"/> Anemia (low blood count)	<input type="checkbox"/> Colon Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney infection <input type="checkbox"/> Degenerative arthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Gout <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Frequent pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Sexual difficulty	<input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Cancer: type _____ <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Multiple Sclerosis (MS) <input type="checkbox"/> Visual Changes <input type="checkbox"/> Blood Clots <input type="checkbox"/> Hepatitis A, B, C <input type="checkbox"/> Dizziness	<input type="checkbox"/> ALS <input type="checkbox"/> HIV <input type="checkbox"/> Tremor <i>Have you used:</i> <input type="checkbox"/> Immuno-suppression? <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
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List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1. _____	_____
2. _____	_____
3. _____	_____

Are you allergic to any medications?

yes no If YES, list the medications.

Are you allergic to metal? yes no

Do you take any medications, including herbal, over-the-counter, and prescription?

yes no If YES, list all medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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<input type="checkbox"/> I do not know the medical history of my biological parents or other family members. (Go on to next section.)	Mother: <input type="checkbox"/> Alive age: _____ <input type="checkbox"/> Deceased at age: _____ due to _____	Father: <input type="checkbox"/> Alive age: _____ <input type="checkbox"/> Deceased at age: _____ due to _____	Number of living brothers/sisters: _____ Number of deceased brothers/sisters: _____ cause(s): _____
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Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:
 Check all that apply:

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Kyphosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back problems	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> None of these
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other

SOCIAL HISTORY

Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widow/widower	Smoking Do you now, or have you ever smoked? <input type="checkbox"/> yes <input type="checkbox"/> no If YES, please complete the following: I smoke _____ packs per day and I have smoked for _____ years. or I did smoke _____ packs per day for _____ years, but I quit smoking _____ years ago. Do you use any smokeless tobacco product? <input type="checkbox"/> yes <input type="checkbox"/> no	Alcohol Do you drink: Beer? <input type="checkbox"/> yes <input type="checkbox"/> no Wine? <input type="checkbox"/> yes <input type="checkbox"/> no "Hard" drinks? <input type="checkbox"/> yes <input type="checkbox"/> no Frequency of drinking: <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> socially (how often _____) <input type="checkbox"/> daily Do you have a history of heavy drinking? <input type="checkbox"/> yes <input type="checkbox"/> no
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Effect of your back/neck pain on your lifestyle. I describe my home setting as supportive of me during this time. <input type="checkbox"/> yes <input type="checkbox"/> no I describe my work setting as supportive of me during this time. <input type="checkbox"/> yes <input type="checkbox"/> no My pain has affected my interaction with my family and friends. <input type="checkbox"/> yes <input type="checkbox"/> no The changes in my lifestyle due to my problem have been difficult for me. <input type="checkbox"/> yes <input type="checkbox"/> no	What is your ability to enjoy life? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
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Please indicate your <u>current work status</u>. <input type="checkbox"/> Working full time <input type="checkbox"/> Working part time <input type="checkbox"/> Seeking employment <input type="checkbox"/> Not working by choice (retired, homemaker, student, etc.) <input type="checkbox"/> Physically unable to work <u>due to</u> back/neck problem <input type="checkbox"/> Physically unable to work <u>not due to</u> back/neck problem	Before having back or neck pain, did you normally work: <input type="checkbox"/> full time <input type="checkbox"/> part time <input type="checkbox"/> neither What is your usual occupation? _____ Do you like your work situation? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A
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Has your pain affected your ability to do your job or any other daily activities? yes no
 If YES, please explain _____

Is there anything we have failed to ask that you believe is important for us to know?
 yes no If YES, please explain: _____

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REVIEW OF SYSTEMS

Do you have any allergies other than to medications (such as to latex, shellfish, etc.)?
 Yes No If YES, describe.

Do you have any of the following?

General:

Recent weight loss of more than 10 pounds? yes no
Recent weight gain of more than 10 pounds? yes no
Fever? yes no
Chills? yes no
Night sweats? yes no

Have you seen your primary care physician in the past year? yes no

Cardiac:

Chest pain yes no
Shortness of Breath yes no

Respiratory:

Wheezing yes no
Pneumonia yes no
Chronic cough yes no

Gastrointestinal:

Abdominal pain yes no
Nausea yes no
Vomiting yes no
Diarrhea yes no
Liver problems yes no

Skin:

Open sores yes no
New moles yes no
Poor healing yes no
Skin infection yes no

Hematologic/Oncologic:

Easy bruising yes no
Blood thinning medications yes no
Blood transfusion yes no
Organ transplant yes no

Bones/Joints:

Shoulder pain yes no
Wrist/hand pain yes no
Hip pain yes no
Knee pain yes no
Lupus yes no
Muscle weakness yes no
Fibromyalgia yes no

Genitourinary:

Abnormal kidney function yes no
Pain with urination yes no
Frequent urinary infections yes no

Nervous System:

Headaches yes no
Tremors yes no
Poor speech yes no
Changes in vision yes no

Mental Health:

Sleep disturbances yes no
Feeling of hopelessness yes no

Endocrine:

Thyroid problems yes no

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BACK PAIN QUESTIONNAIRE

If you have LOW BACK pain- complete this page,
if you only have neck pain, skip this page.

Please Read: This questionnaire is designed to give us information on how your back(or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark the one box 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 is very painful.
- 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 everyday in most aspects of self care.
- I do not get dressed, wash with difficulty, an 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, for example, 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 very light weights.
- I cannot lift or carry anything at all.

Section 4 -- Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than 1/2 mile.
- Pain prevents me walking more than 100 yards.
- 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 still in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me sitting more than 1/2 hour.
- Pain prevents me sitting more than 10 mins.
- 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 1/2 an hour.
- Pain prevents me from standing for more than 10 mins.
- 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 get less than 6 hours sleep.
- Because of pain I get less than 4 hours sleep.
- Because of pain I get less than 2 hours 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 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 without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I can 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.

NECK PAIN QUESTIONNAIRE

If you have NECK pain- complete this page.

Please Read: This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please just mark the one choice which most closely describes your problem right now.

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 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 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 everyday in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

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 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, for example, 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 very light weights.
- I cannot lift or carry anything 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 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 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 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1 -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 hours sleepless).

Section 5 – Headaches

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

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