Neurological Surgery Phone (310) 551-0690 Fax (310) 659-8869

Patient Information Questionnaire

Please print clearly and give this to the receptionist when you are done.

The doctor will be with you shortly. Thank you!!!

		Today's date	
		Date of injury	
Mr./ Mrs./ Ms	First	middle	last
	THSt	madic	iast
Home address	Number	street	apt. #
			•
	City	state	zip code
Date of birth	_/	Sex F M	
Marital Status		Spouse Name:	
Home phone ()	Work phone ()
Cell phone ()	email	
Referred by:		Social Security #	
Type of case: W/	/comp Persona	al injury Private ins	Medicare
Employer:		Phone no. ()	
Address:			
	Number	street	suite
	City	state	zip code
Attorney for this i	njury:	Phone no. ()
Address:			
	Number	street	suite
	City	state	zip code

${\bf DAVID~A.~DITSWORTH,~M.D.}$

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Please complete the following if you have consulted with other surgeons or pain-management doctors. Please check off all that apply.

Doctor:						
Date you last saw this Doctor:						
This Doctor diagnosed you with:						
This Doctor: () ordered MRIs () ordered CT scan () ordered X rays						
This Doctor suggested the following approaches to your condition: () epidural injections () medications () physical therapy () open back surgery () fusion surgery () microdiscectomy () artificial disc () other: Please indicate the types of procedures you have had and the dates that these procedures were performed on:						
Doctor:() orthopedic surgeon () neurosurgeon () pain-management () Family Doctor () other:						
Doctor's address/ phone #:						
Date you last saw this Doctor: This Doctor diagnosed you with:						
This Doctor: () ordered MRIs () ordered CT scan () ordered X rays						
This Doctor suggested the following approaches to your condition: () epidural injections () medications () physical therapy () open back surgery () fusion surgery () microdiscectomy () artificial disc () other: Please indicate the types of procedures you have had and the dates that these procedures were performed on:						

DAVID A. DITSWORTH, M.D. Neurological Surgery Phone (310) 551-0690 Fax (310) 659-8869

Authorization for Release of Medical Records

I,	Patient's name
Authorize the re	elease of my medical records to:
THE 920 S. ROBER	A. DITSWORTH, M.D. E BACK INSTITUTE ETSON BOULEVARD, UNIT 6
LOS ANGE	ELES, CALIFORNIA 90035
cords requested from:	
te (s) of Treatment:	
gnature of patient	Date signed
rint name	Date of birth

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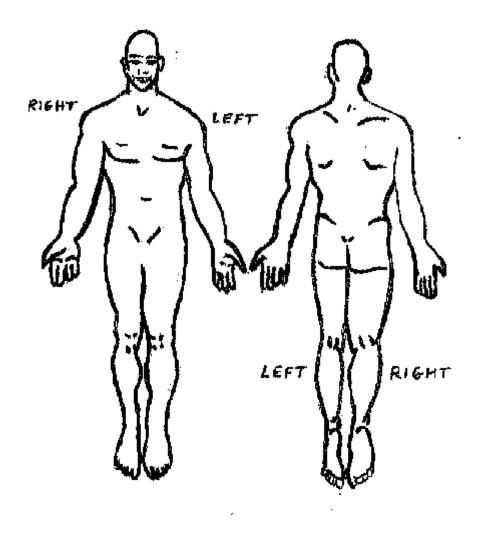
New Patient Questionnaire

Name		
Age	Date	

Medical Complaints

Please indicate the areas in which you are experiencing **PAIN** on the models below.

[] none



PAIN

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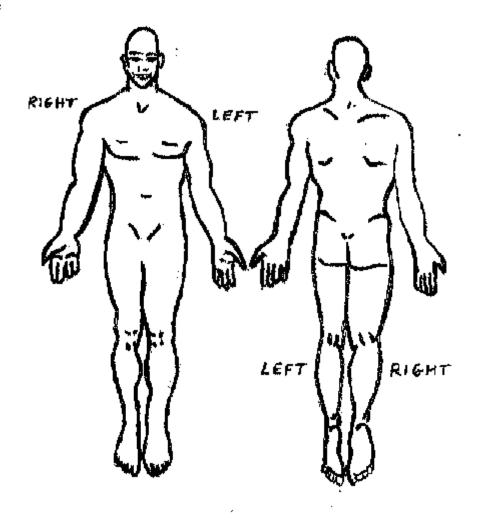
New Patient Questionnaire

Name		
Age	Date	

Medical Complaints

Please indicate the areas in which you are experiencing **WEAKNESS** on the models below.

[] none



WEAKNESS

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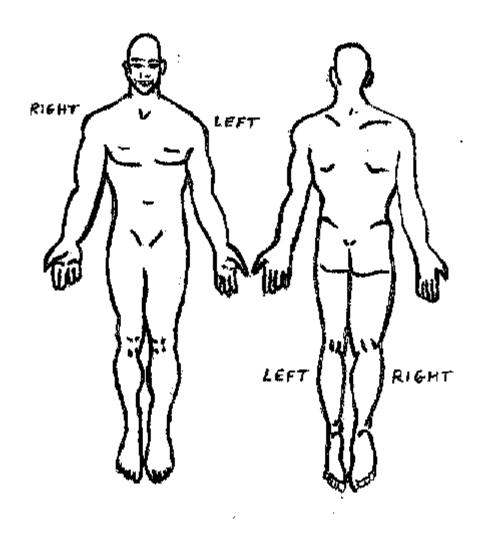
New Patient Questionnaire

Name	
Age	Date

Medical Complaints

Please indicate the areas in which you are experiencing $\underline{\mathbf{NUMBNESS}}$ on the models below.

[] none



NUMBNESS

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		ame		
			Da	te
	Medical Co	_		
1. Allergies: Is there a history of an such as iodine? () No (If yes, please describe	() Yes	•		
2. What is your chief complaint? (w	hat bothers you	u most?)		
3. Describe your pain. (i.e. sharp, be	urning, etc.) _			
	() left () back Where?	() right () front		
6. Have you noted any color changes If so, please describe				
7. Have you noted any swelling of th If so, please describe				() Feet
8. Does anything make the pain wor	:se?			
9. Have you had any bowel or blade	der changes? _			
10. Have you ever had spine surger	y?			
11. Have you had any prior problems Symptoms	•		· · ·) no
12. Have you had any prior treatmen If yes, please describe				
13. Have you seen a chiropractor If yes, please provide name o				
14. What do you think caused the p	oroblem?			

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		Name		
		Age	Date	
	<u>H</u> J	EALTH QUESTIONNAIRE		
N A ME		ACE	DATE	
NAME ADDRESS				
ADDRESS				
HISTORY OF PAST ILLNESS		e list all medical conditions that	·	
				_
OPERATIONS: Have you had any surgery?			No. Y	z Pec
trave you had any surgery?				——
INJURIES: Have you had any major fryes, please describe	or injurie	es?	No Y	'es
ii yes, pieuse deseribe				
FAMILY HISTORY: Is there any	maior di	sease or illness that runs in your fam	ily No Y	7es
If yes, please describe			110 1	. 03
J 1 1 7 F				
SOCIAL HISTORY: Marital Status:				
Do you Smoke? No	Vac	If you have much and what?		
Alcoholic Reverages? No	Voc	If yes, how much and what? If yes, how much and what?		
Alcoholic Beverages: No	168	if yes, now much and what:		
SYSTEMIC REVIEW: Have you h	nad anv	problem with any of the following?		
Skin	No			
Head-Eyes-Ears-Nose-Throat	No	Yes		
Neck	No	Yes		
Lungs	No			
Genitourinary	No			
Blood	No	Yes		
Heart	No	Ves		
Gastrointestinal	No	Vas		
Locomotor-Musculoskeletal	No	Vas		
Neuro-Psychiatric	No	Yes		
Women's health				
women's nearm	No	Yes		
Source of information, if other than p	ationt:			
Source of information, if other than p	oatient: _			
Signature of person acquiring this inf	ormatio	on:		
Doctor			Signature of patien	
Doctor		Date	Signature of patien	

1 tailic.			_
D	TO 1	- ·	
Date of Birth:	Phone #	Examiner:	
			-

THE OSWESTRY* LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your *low back and/or leg pain* has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but

PLEASE JUST CIRCLE THE ONE CHOICE WHICH CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW. PLEASE FAX THIS FORM TO (310)-659-8869 AFTER YOU HAVE COMPLETED IT.

SECTION 1--Pain Intensity

Name.

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care

- I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.
 - *Modified with "and/or leg pain".

SECTION 6 -- Standing

- A I can stand as long as I want without pain
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

Today's Date

SECTION 7--Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from social life at all.

SECTION 9--Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms off travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Disability index score: ______% Evaluator: