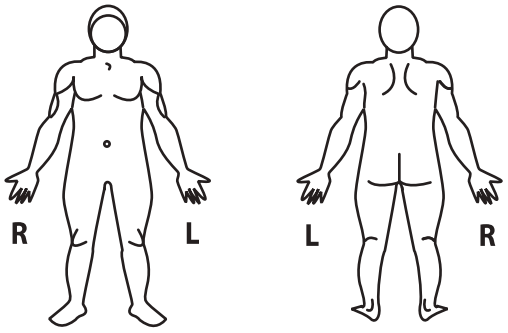
SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

Surgical and Nonsurgical Intervention

FOLLOW-UP ASSESSMENT

Name: _____ DOB: _____ Primary Care Physician: _____ Date: _____



1. Please shade in only the area(s) of your pain that we are **seeing you for <u>today.</u>**
2. Status of pain since your last visit here:
   ❒Worse ❒Better ❒Same
3. Frequency: ❒Constant ❒Comes/Goes ❒Rarely
4. Please indicate your level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

5. Check the words that best describe the pain for which you are being seen:
   ❒Aching ❒Burning ❒Dull ❒Numbing ❒Sharp
   ❒Cramping ❒Radiating ❒Stabbing ❒Stinging ❒Tingling
6. Please indicate which (if any) treatments you've had for the condition for which we are seeing you today.
   ❒Physical Therapy ❒Chiropractic Care ❒Medications ❒Massage ❒Injections*

*If yes to Injections, did you get relief? ❒Yes ❒No If yes, what percentage of relief? _____%
If yes, for how long? _____ minutes _____ hours _____ days _____ weeks _____ months

7. Are you working? ❒Full Duty ❒Light Duty ❒Not Working
8. Since your last visit here, have you seen your Primary Care Physician, been hospitalized or had surgery?
   - If yes, please explain:

_____
_____

9. Please check the activities that increase, decrease or do not change the pain for which we are treating you

ACTIVITY	INCREASE PAIN	DECREASE PAIN	NO CHANGE
Sitting	❒	❒	❒
Standing	❒	❒	❒
Walking	❒	❒	❒
Lying Down	❒	❒	❒
Changing Positions	❒	❒	❒
Leaning Forward	❒	❒	❒

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10. Mark the following signs and/or symptoms you experience: If none apply, please check: ❒ None of these apply to me.

Constitutional:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Malaise
- ❑ Night sweats
- ❑ Weakness
- ❑ Weight gain
- ❑ Weight loss

Cardiovascular
- ❑ Chest pain
- ❑ Cyanosis
- ❑ Heart murmur
- ❑ Leg swelling
- ❑ Syncope
- ❑ Irregular heartbeat/ palpitations

Metabolic/Endocrine
- ❑ Cold intolerant
- ❑ Hair loss
- ❑ Heat intolerant

Integumentary
- ❑ Itchy skin
- ❑ Rash
- ❑ Skin infections
- ❑ Skin lesion

Hematologic
- ❑ Bleeding
- ❑ Bruising

HEENT
- ❑ Blurred vision
- ❑ Double vision
- ❑ Dysphagia
- ❑ Ear drainage
- ❑ Facial pain
- ❑ Headache
- ❑ Hearing loss
- ❑ Hoarseness
- ❑ Nasal congestion
- ❑ Ringing in ears
- ❑ Vertigo
- ❑ Vision loss

Gastrointestinal
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Black tarry stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice
- ❑ Loss of appetite
- ❑ Nausea
- ❑ Vomiting

Neurological
- ❑ Difficulty walking
- ❑ Dizziness
- ❑ Poor coordination
- ❑ Memory impairment
- ❑ Muscle weakness
- ❑ Paresthesia
- ❑ Seizures
- ❑ Tremors

Respiratory
- ❑ Asthma
- ❑ Chest pain (respiratory)
- ❑ Cough
- ❑ Dyspnea
- ❑ Recent infections
- ❑ Known TB exposure
- ❑ Wheezing

Genitourinary
- ❑ Dysuria
- ❑ Frequent urination
- ❑ Hematuria
- ❑ Urge incontinence
- ❑ Urinary incontinence

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Immunological
- ❑ Bee sting allergy
- ❑ Contact allergy
- ❑ Contact dermatitis
- ❑ Environmental allergies
- ❑ Food allergies
- ❑ Seasonal allergies

11. Have you been admitted to the hospital for any reason in the last 30 days? ❒Yes ❒No
    - Discharge Date: _____
    - Diagnosis: _____
12. Do you take blood thinners (including aspirin)? ❒Yes ❒No If yes, medication: _____
    - Diagnosis: _____
13. Have you ever used tobacco products: ❒Yes ❒No Status: ❒Current User ❒Former User
14. Do you take medications for osteoporosis (brittle bones)? ❒Yes ❒ No If yes, medication: _____
15. Do you take medications for high blood pressure? ❒Yes ❒ No If yes, medication: _____
16. Have you received an influenza vaccine (flu): ❒Yes ❒No Date: _____ Best Estimate: _____
17. Have you received a pneumonia vaccine? ❒Yes ❒No Date: _____ Best Estimate: _____
18. Have you fallen in the last year? ❒Yes ❒No # of falls: _____ Did it result in injury? ❒Yes ❒No

Name: _____ Date: _____

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Family Hx Dx: ❒Mother ❒Father ❒Sister ❒Brother Dx:_____
Is pt. post op SSS? ❒Yes ❒No ❒Surgery: _____
Assistive device? ❒Cane ❒Walker ❒Rolling Walker ❒Other

Provider:

50+ Does pt. have hip, spine/radius fx today? ❒Yes ❒No
If yes, refer to PCP, Dr. _____ for treatment of osteoporosis.

65+ Is pt. at risk for falls? ❒ Yes ❒ No
Balance/Strength/ Gait Training (***circle***) Advised PT Declined PT Home PT HEP N/A Other:_____

❒Address BMI: ❒Did not counsel ❒Child BMI ❒Underweight
❒Hypertension >120/80: ❒Diet ❒Activity ❒Referral

Tech: _____

Veterans Rand 12 Item Health Survey (VR-12)

First name: _____ Last name: _____ Date of birth:_____

The following questions ask for your views about your health—how you feel and how well you are able to do your usual activities. All kinds of people across the country are being asked these same questions. Their answers and yours will help to improve health care for everyone. There are no right or wrong answers; please choose the answer that ***BEST FITS YOUR LIFE RIGHT NOW.***

Answer each question by checking the best response.

In general, would you say your health is: ❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

The following questions are about activities you might do during a typical day. Does your health not limit you in these activities? If so, how much?	Yes Limited a lot	Yes Limited a little	No Not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	❒	❒	❒
Climbing several flights of stairs?	❒	❒	❒

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?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❒	❒	❒	❒	❒
Were limited in the kind of work or other activities:	❒	❒	❒	❒	❒

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)?	No None of the time	Yes A little of the time	Yes Some of the time	Yes Most of the time	Yes All of the time
Accomplished less than you would like:	❒	❒	❒	❒	❒
Didn't do work or other activities as carefully as usual:	❒	❒	❒	❒	❒

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

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 the time	Most of the time	A good bit of the time	Some of the time	A little of the time
Have you felt calm and peaceful?	❒	❒	❒	❒	❒
Did you have a lot of energy?	❒	❒	❒	❒	❒
Have you felt downhearted and blue?	❒	❒	❒	❒	❒

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

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

Now, we'd like to ask you some questions about how your health may have changed.

Compared to one year ago:	Much better	Slightly better	About the same	Slightly worse	Much worse
How would you rate your physical health in general now:	❒	❒	❒	❒	❒
How would you rate your emotional problems:	❒	❒	❒	❒	❒

Your answers are important!
Thank you for completing this questionnaire!