SPINE INTERVENTION

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Thank you for entrusting our practice with your health. To help us meet your expectations, please fill this form and email to: info@spineintervention.co.za or reception@spineintervention.co.za

PATIENT QUESTIONNAIRE

Surname _____ Initials _____ Title _____

Full names _____ Age _____

Date of birth _____ ID No _____

Marital status _____ Occupation _____

Cell No _____ Employer _____

Email _____ Work tel _____

Medical aid _____ Dependent no _____

Option _____ Medical aid no _____

Full name and surname of main member _____

ID number of main member _____

Home address _____

_____

OTHER

Referred by _____ Email_____

General Practitioner _____ Email _____

Next of Kin and contact details _____

What is the problem? Back ☐ Neck ☐ How long have you had this problem? _____

Was it due to an injury Yes ☐ No ☐ Did it occur at work? Yes ☐ No ☐ N/A ☐

Is there a legal case? Yes ☐ No ☐ N/A ☐

What are your symptoms / Where is the pain?

_____

_____

_____

_____

Do you have any of the following problems?

Is the pain worse at night? Yes ☐ No ☐

Does the pain wake you from sleep? Yes ☐ No ☐

Does coughing/sneezing affect the pain? Yes ☐ No ☐

Do your legs tire / hurt if you walk too far? Yes ☐ No ☐

If YES: How far can you walk? <100m <300m >300m (please circle)

Is it relieved by resting? Yes ☐ No ☐

Is it relieved by bending forward? Yes ☐ No ☐

Do you have problems emptying your bladder? Yes ☐ No ☐

Do you lose control of your bladder / leak urine? Yes ☐ No ☐

Are you constipated? Yes ☐ No ☐

Do you lose control of your bowels / leak stools? Yes ☐ No ☐

Have you had any consultations / treatment for your CURRENT back / neck problem?

Seen your General Practitioner Yes ☐ No ☐ Who? _____

Seen a Specialist Yes ☐ No ☐ Who? _____

Seen a Physiotherapist / Chiropractor Yes ☐ No ☐ Who? _____

X-Rays Yes ☐ No ☐ Where? _____

MRI / CT scan Yes ☐ No ☐ Where? _____

Have you ever had surgery on you back / neck before? Yes ☐ No ☐

If YES, complete the following:

1. Type of surgery _____
   a. Date _____
   b. Surgeon _____ Hospital _____
   c. Did it make your pain Better ☐ Worse ☐
2. Type of surgery _____
   a. Date _____
   b. Surgeon_____ Hospital _____
   c. Did it make your pain Better ☐ Worse ☐
3. Type of surgery _____
   a. Date _____
   b. Surgeon _____ Hospital _____
   c. Did it make your pain Better ☐ Worse ☐
4. Type of surgery _____
   a. Date _____
   b. Surgeon _____ Hospital _____
   c. Did it make your pain Better ☐ Worse ☐

Do you have any <u>MEDICAL CONDITIONS</u> from which you currently suffer / suffered before / receive treatment for at present or received in the past? Yes ☐ No ☐

Please list:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list **ALL** medications / supplements / over-the-counter medication you are taking:

1. _____ Reason _____
2. _____ Reason _____
3. _____ Reason _____
4. _____ Reason _____
5. _____ Reason _____
6. _____ Reason _____
7. _____ Reason_____
8. _____ Reason _____

Are you using any **BLOOD THINNING MEDICATION** such as Disprin / Ecotrin / Plavix / Clopidogrel /

Warfarin or any other? Yes ☐ No ☐

Are you **ALLERGIC** to any medication / food / material? Yes ☐ No ☐

Please list: _____

Have you had any surgery before, <u>OTHER THAN</u> spine surgery? Yes ☐ No ☐
Please list:

1. _____ Year _____ Surgeon _____
2. _____ Year _____ Surgeon _____
3. _____ Year _____ Surgeon _____

Social History

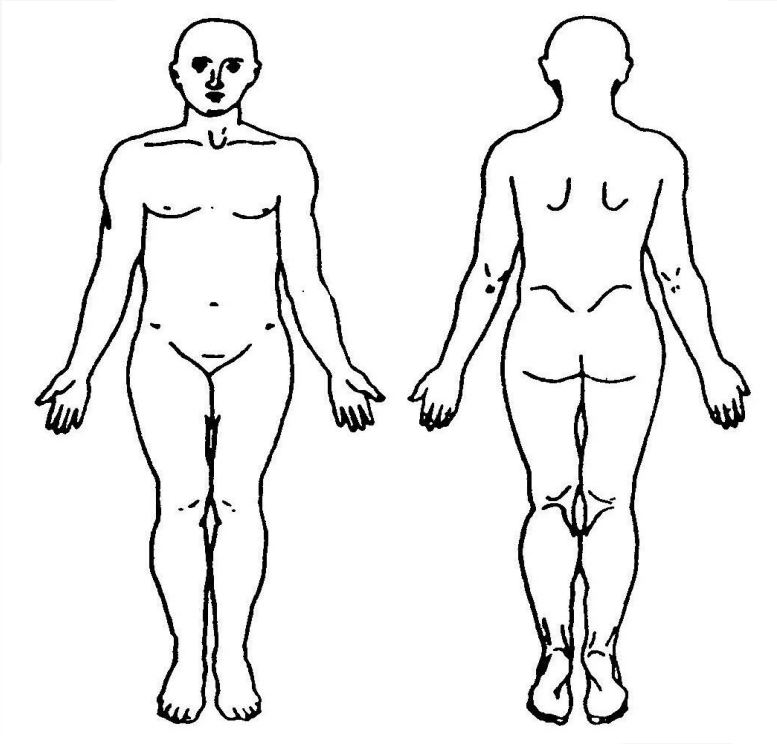
Marital status	Married ☐	Separated ☐	Divorced ☐	Single ☐	Widowed ☐
Smoking	Yes ☐	No ☐	Previously ☐	**Amount** _____ per day	
Alcohol day	Yes ☐	No ☐	Previously ☐	**Amount** _____ drinks per	

Current employment

- o Working full-time
- o Working part-time
- o Seeking employment
- o Not working by choice (retired, homemaker, student, etc.)
- o Physically unable to work **DUE** to back / neck problem

Indicate on the sketch where you are experiencing pain

Weight: _____kg Height: _____m



VISUAL ANALOGUE PAIN SCALE

Please mark using an "**X**" how much pain you have on a scale of 0 - 10

0 1 2 3 4 5 6 7 8 9 10

No Pain *Moderate pain* *Worst possible pain*

DN 4 QUESTIONNAIRE

Does the pain have one or more of the following characteristics?

Burning YES ❑ NO ❑ Painful or cold YES ❑ NO ❑

Electric shocks YES ❑ NO ❑

Is the pain associated with one or more of the following symptoms in the same area?

Tingling YES ❑ NO ❑ Pins and needles YES ❑ NO ❑

Numbness YES ❑ NO ❑ Itching YES ❑ NO ❑

NECK PAIN

NECK DISABILITY INDEX (NDI)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 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 worst imaginable at the moment.

Section 2 – Personal Care (Washing, dressing, etc.)
- ☐ (0) I can look after myself normally, without causing 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 do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ (0) I can lift heavy weights without extra pain.
- ☐ (1) I can lift heavy weights, but it gives extra pain.
- ☐ (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ (3) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ (4) I can lift very light weights.
- ☐ (5) I cannot lift or carry anything at all.

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

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

Section 6 – Concentration
- ☐ (0) I can concentrate fully when I want to with no difficulty.
- ☐ (1) I can concentrate fully when I want to with slight difficulty.
- ☐ (2) I have a fair degree of difficulty in concentrating when I want to.
- ☐ (3) I have a lot of difficulty in concentrating when I want to.
- ☐ (4) I have a great deal of difficulty in concentrating when I want to.
- ☐ (5) I cannot concentrate at all.

Section 7 – Work
- ☐ (0) I can do as much work 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 work at all
- ☐ (5) I can't do any work at all.

Section 8 – Driving
- ☐ (0) I can drive my car without any neck pain.
- ☐ (1) I can drive my car as long as I want, with sight pain in my neck.
- ☐ (2) I can drive my car as long as I want, with moderate pain in my neck.
- ☐ (3) I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ (4) I can hardly drive at all because of severe pain in my neck.
- ☐ (5) I can't drive my car at all.

Section 9 - Sleeping
- ☐ (0) I have no trouble sleeping.
- ☐ (1) My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ (2) My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ (3) My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ (4) My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ (5) My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation
- ☐ (0) I am able to engage in all recreation activities with no neck pain at all.
- ☐ (1) I am able to engage in all reaction activities with some pain in my neck.
- ☐ (2) I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ☐ (3) I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ (4) I can hardly do any recreation activities because of pain in my neck.
- ☐ (5) I can't do any recreation activities at all.

LOWER BACK PAIN

OSWESTRY LOW BACK PAIN DISABILITY INDEX

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statement in any one section apply but please just shade out the spot that indicate the statement which most clearly describes your problem.

Section 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 worst imaginable at the moment.

Section 2 – Personal Care (Washing, dressing, etc.)

- ☐ (0) I can look after myself normally, without causing 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 do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

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

Section 4 – Walking

- ☐ (0) Pain does not prevent me walking any distance
- ☐ (1) Pain prevents me from walking more than ½ mile
- ☐ (2) Pain prevents me from walking more than ½ mile
- ☐ (3) Pain prevents me from walking more than 100 yards
- ☐ (4) I can only walk using a stick or crutches
- ☐ (5) I am in bed most of the time

Section 5 – sitting

- ☐ (0) I can sit in any chair as long as I like
- ☐ (1) I can only sot in my favorite chair as long as I like
- ☐ (2) Pain prevents me sitting more than one hour
- ☐ (3) Pain prevents me from sitting more than 30 minutes
- ☐ (4) Pain prevents me from sitting more than 10 minutes
- ☐ (5) Pain prevents me from sitting at all

Section 6 – Standing

- ☐ (0) I can stand as long as I want without extra pain
- ☐ (1) I can stand as long as I want but it gives me extra pain
- ☐ (2) Pain prevents me from standing for more than 1 hour
- ☐ (3) Pain prevents me from standing for more than 30 minutes
- ☐ (4) Pain prevents me from standing for more than 10 minutes
- ☐ (5) Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ (0) My sleep is never disturbed by pain
- ☐ (1) My sleep is occasionally disturbed by pain
- ☐ (2) Because of pain I have less than 6 hours sleep
- ☐ (3) Because of pain I have less than 4 hours sleep
- ☐ (4) Because of pain I have less than 2 hours sleep
- ☐ (5) Pain prevents me from sleeping at all

Section 8 – Sex Life (if applicable)

- ☐ (0) My sex life is normal and causes no extra pain
- ☐ (1) My sex life is normal but cause some extra pain
- ☐ (2) My sex life is nearly normal but is very painful
- ☐ (3) My sex life is severely restricted by pain
- ☐ (4) My sex life is nearly absent because of pain
- ☐ (5) Pain prevents any sex life at all

Section 9 – Social Life

- ☐ (0) My social life is normal and gives me no extra pain
- ☐ (1) My social life is normal but increases the degree of pain
- ☐ (2) Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ (3) Pain has restricted my social life and I do not go out as often
- ☐ (4) Pain has restricted my social life to my home
- ☐ (5) I have no social life because of pain

Section 10 – Travelling

- ☐ (0) I can travel anywhere without pain
- ☐ (1) I can travel anywhere but it gives me extra pain
- ☐ (2) Pain is bad but I manage journeys over two hours
- ☐ (3) Pain restricts me to journeys of less than one hour
- ☐ (4) Pain restricts me to short necessary journeys under 30 minutes
- ☐ (5) Pain prevents me from travelling except to receive treatment

Modified Zung Depression Index

Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1. I feel downhearted and sad				
2. Morning is when I feel best				
3. I have crying spells or feel like it				
4. I have trouble getting to sleep at night				
5. I feel that nobody cares				
6. I eat as much as I used to				
7. I still enjoy sex				
8. I notice I am losing weight				
9. I have trouble with constipation				
10. My heart beats faster than usual				
11. I get tired for no reason				
12. My mind is as clear as it used to be				
13. I tend to wake up too early				
14. I find it easy to do the things I used to				
15. I am restless and can't keep still				
16. I feel hopeful about the future				
17. I am more irritable than usual				
18. I find it easy to make a decision				
19. I feel quite guilty				
20. I feel that I am useful and needed				
21. My life is pretty full				
22. I feel that others would be better off if I were dead				
23. I am still able to enjoy the things I used to				

Modified Somatic Perceptions Questionnaire

Please describe how you have felt during the PAST WEEK by marking a check mark (√) in the appropriate box. Please answer all questions. Do not think too long before answering.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
Heart rate increase				
Feeling hot all over				
Sweating all over				
Sweating in a particular part of the body				
Pulse in neck				
Pounding in head				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal				
Nausea				
Butterflies in stomach				
Pain or ache in stomach				
Stomach churning				
Desire to pass water				
Mouth becoming dry				
Difficulty swallowing				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles				

POPI ACT: PATIENT CONSENT FORM

Dear Patient,

As you might be aware of the Protection of Personal Information Act of 2013 (POPIA) which came into full effect as of the 1st of July 2021, Spine Intervention herewith requires you to sign this consent form as a way of you giving us permission to have your personal information, medical records, and other relevant information released from our office to other doctors, pathologies, radiologists, medical aids and the hospital - who might be involved in ensuring your optimal care.

The National Health Act allows for the sharing of patient information where it is in the patient's best interest and necessary for their care. Records can be shared and accessed by a treating doctor, pathology laboratory and other specialists.

Please note that Spine Intervention will require that all parties (doctors, pathologies, and radiologists) acknowledge their compliance with POPIA prior to sharing any personal and medical information with the party.

Kindly indicate below if you hereby grant permission to have your personal information, medical records and any other relevant information submitted to the relevant parties. Note that it is in your best interests to provide the information to ensure that optimal care is provided by Spine Intervention.

YES NO

_____

PATIENT'S SIGNATURE