7720 S. Broadway Suite 320
Phone- 720-452-3355 Fax-303-955-2513

Patient Information

Patient Last Name-______________________ First- ___________________________ Middle Initial-_______

Address- __________________________ City- ____________________ State- ____ Zip Code- __________

Home Phone- _______________ Cell Phone-___________ Work Phone- _______________________

Email Address-______________________________ Social Security #______________________________

Date of Birth- ____________________ Sex- M or F Martial Status-________

Employer- ________________________ Phone- ____________________

Emergency Contact- ____________________ Relationship- ______________________________

Primary Care Physician- ____________________ Phone- _______________ Fax- ______________________

Is this a work or auto injury? Yes No

Primary Insurance-

Insurance Name-__________________________ Policy# __________________ Group# ________________

Insurance Address-____

Insurance Phone# ___________________________ Copay$_________________ Effective Date- ______

Name of Person Insured- _________________________ Relationship- ___________________________

Social Security- __________________________________ Date of Birth-___________________________

Employer-__________________________________ Address- _______________________________

Secondary Insurance (if applicable)

Insurance Name-__________________________ Policy#___________________ Group#_____________

Insurance Address- ____

Insurance Phone- _________________________ Copay$_______________ Effective Date- ____________

Name of Insured- ___________________________ Relationship- _________________________________

Social Security Number- ____________________________ Date of Birth- __________________________

Employer- __________________________________ Address- __________________________________

I hereby authorize **Colorado Spine & Scoliosis** to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. **Assignment and Release-** I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information required in processing of this claim and all future claims.

Patient / Authorized Signature-____ **Date-**_________________

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Financial Policy

This is an agreement between **Colorado Spine and Scoliosis** and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Colorado Spine and Scoliosis.

By executing this agreement, you are agreeing to pay for all services that are received.

Contracted Insurance- If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pat that at time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral, you are responsible to obtaining it. Failure to do so may result in a lower payment from the insurance company.

Non-Contracted Insurance- Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determinations of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral, you are responsible for obtaining it.

Required payments- Any co-payments required by an insurance company must be paid at the time of service.

Worker's Compensation- We require approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury- If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the balance remains the patient's responsibility. We will not bill your attorney for charges incurred due to a personal injury case.

Payment Options if you have no insurance-
You choose to pay by_cash,_check,_or credit card on the day that treatment is rendered.

Returned Checks- There is a fee of $25 for any checks returned by your bank.

Statement- If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments- Unless other arrangements are approved by us in writing the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Credit History- We have the option to report your account status to any credit reporting agency such as a credit bureau.
Past due accounts- We have the right to deny any future visits and have the right to require patients with a balance pay their balance to zero ($0.00) prior to receiving further services by our practice. If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance toa lawyer, you agree to pay all lawyers fees which we incur plus all court cost.

Waiver of confidentiality- You understand if this account is submitted to an attorney or collection agency. If we must litigate in court, or if you are past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Co-signature- If this or another financial policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name-__________________________ Responsible Party-__________________________

Signature-_____________________________ Date-____________________________________

7720 S. Broadway Suite 320
Phone- 720-452-3355 Fax-303-955-2513

HIPPA Privacy Notice

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

We understand that the privacy of your personal information is important to you. As you physician, 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 call our office at 720-452-3355.

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. The 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 your treatment, we will collect health information regarding diagnosis, treatment plans, progress and any test results or imaging.

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 healthcare 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 uses of your information require a signed authorization by you, the patient or guardian, and can be revoked at any time with a written request. Colorado Spine & Scoliosis does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organization or government agencies.

We may contact you to provide appointment reminder of information about treatment alternatives or other health related benefits and services that may be of interest to you.

Safeguarding Your Personal and Health Information

We required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (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. Colorado Spine & Scoliosis maintains physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel that your privacy has been violated, you have the right to file a complaint with the Denver Health and Human Services. The complaint in no way influences your course of treatment with Colorado Spine & Scoliosis.

Changes of Our Privacy Policy

All new patients will receive a copy of our privacy policy. Colorado Spine & Scoliosis occasionally reviews its privacy policy and reserves the right to amend it. Notifications of changes will be available at the from 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 of 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.

Patient Acknowledgement

I, ____________________________, have received and reviewed a copy of Colorado Spine & Scoliosis HIPPA Privacy Notice.

Signature-__________________________________ Date-____________________

7720 S. Broadway Suite 320
Phone- 720-452-3355 Fax-303-955-2513

Medical Information Release Form
(HIPPA Release Form)

Name-______________________________ Date of Birth-__________________

Patient Disclosure Record-

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individuals are also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as correspondence to the individual's office instead of the individual's home.

___ Patient Initials (I have read the above policy)

Release of Information-

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

__ Spouse ______________________________

__Child(ren) ___________________________

__ Other _______________________________

__ Information is *NOT* to be release to anyone.

Contact Information-

Please call:
- __ Cell
- __ Home
- __ Work

If Unable to reach me:
- __ Leave a detailed message
- __ Leave a message asking to return your call
- __ Other ____________________________

Written Correspondence-
- __ Home Address
- __ Work Address

This **Release of Information** will remain in effect until terminated by me in writing.

Signed-________________________________ Date- _____________________

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Cancellation / No Show Policy

1. *Cancellation/ No Show for Appointment-* We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we ae unable to schedule you for a visit, due to a seemingly "full" schedule. If an appointment is not cancelled at least 24hrs. in advance you will be charged a $50.00 (fifty dollars) fee, this will not be covered by your insurance company.

2. *Scheduled Appointments-* We understand that delays can happen however we must try and keep the other patient's appointment and doctor on time. If you are 15minutes past their scheduled time, we will have to reschedule your appointment.

3. *Cancellation/ No show for Surgery-* Due to the large block of time needed to schedule surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a $100.00 (one hundred) fee; this will not be covered by your insurance company.

Patient Name-________________________________

Signature-___________________________________

Date- __________________

ANANT KUMAR, M.D.

New Patient Questionnaire
Thoracic and Lumbar Spine

Please answer all questions completely

Colorado Back and Spine – Dr. Anant Kumar

Date:______________

Patient Name:____

Referring doctor name and address:_______________________________________

If you were not referred by a physician, how did you find our office?________________

Primary care doctor name and address:_____________________________________

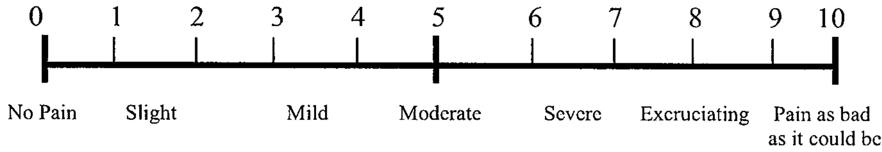
1. Your age:__________ Years Gender: ☐ Male ☐ Female
2. Symptoms: ☐ BACK pain ☐LEG pain ☐ Numbness ☐ Weakness ☐ Other_______
3. How long have you had your symptoms?______________________________
4. What caused your symptoms? ☐ Unknown ☐ Injury ☐ Other ____________________
5. Have your symptoms improved or worsened recently? ☐ Improved ☐ Worsened
6. When did and what caused your symptoms improve or worsen?______________________

What % of your symptoms is in the BACK and LEG? (please check one box)	What % of your symptoms is in each LEG? (please check one box)
☐ BACK 0%, LEG 100%	☐ No LEG symptoms
☐ BACK 10%, LEG 90%	☐ Right 0%, Left 100%
☐ BACK 25%, LEG 75%	☐ Right 10%, Left 90%
☐ BACK 50%, LEG 50%	☐ Right 25%, Left 75%
☐ BACK 75%, LEG 25%	☐ Right 50%, Left 50%
☐ BACK 90%, LEG 10%	☐ Right 75%, Left 25%
☐ BACK 100%, LEG 0%	☐ Right 90%, Left 10%
	☐ Right 100%, Left 0%

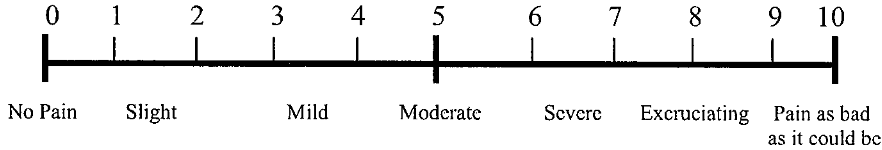
Where in your LEG do you have PAIN or TINGLING?		Where in your LEG do you have NUMBNESS		Where in your LEG do you have WEAKNESS	
Right	**Left**	**Right**	**Left**	**Right**	**Left**
☐ None	☐ None	☐ None	☐ None	☐ None	☐ None
☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock	☐ Buttock
☐ Thigh, back	☐ Thigh, back	☐ Thigh	☐ Thigh	☐ Thigh	☐ Thigh
☐ Thigh, front	☐ Thigh, front	☐ Calf	☐ Calf	☐ Calf	☐ Calf
☐ Calf	☐ Calf	☐ Ankle	☐ Ankle	☐ Ankle	☐ Ankle
☐ Foot	☐ Foot	☐ Foot/toes	☐ Foot/toes	☐ Foot	☐ Foot

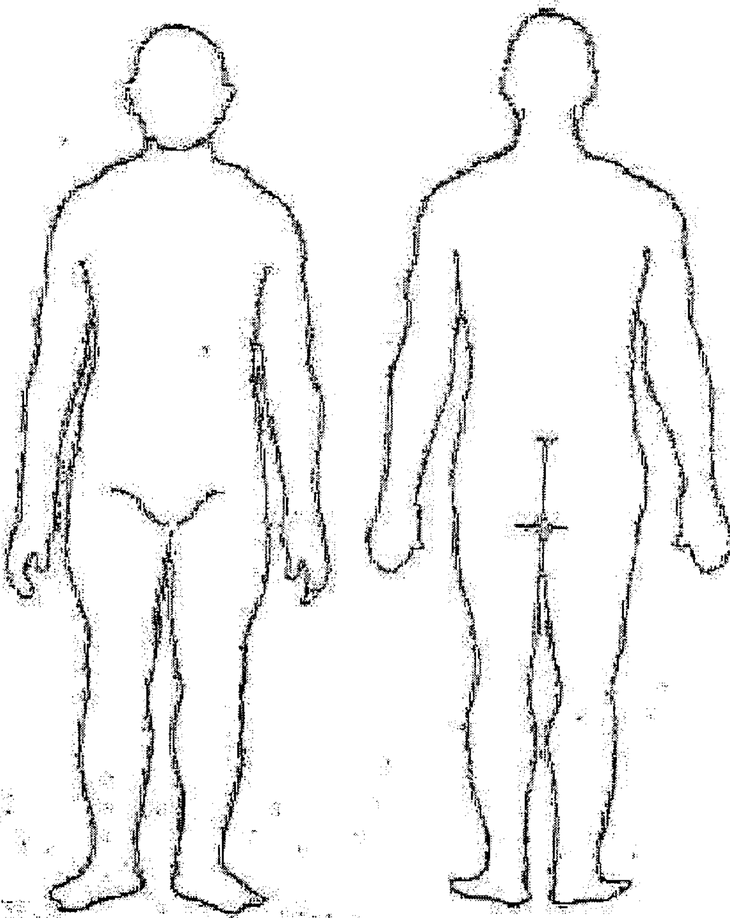
Colorado Back and Spine – Dr. Anant Kumar

MY BACK PAIN IS (circle number)



MY LEG PAIN IS (circle number)





Please mark the areas on the diagram where you are having symptoms and the location where the symptoms radiate.

Please use the following symbols to indicate the type of symptoms and the location of the symptoms:

Pain= -----------------------------

Pins and Needles= 00000000

Numbness= XXXXXXXXXXX

Colorado Back and Spine – Dr. Anant Kumar

7. **How does your pain travel:** ☐ Stays in my BACK ☐ Starts in the BACK and goes down the LEG
8. **The worst position for pain is**: ☐ No pain ☐ Sitting ☐ Standing ☐ Walking
9. **Bending forward?** ☐ Increases the pain ☐ Decreases the pain ☐ No effect
10. **Lying down?** ☐ Increases the pain ☐ Decreases the pain ☐ No effect
11. **How many minutes can you STAND without pain?** ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
12. **How many minutes can you WALK without pain?** ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
13. **Does coughing or sneezing increase your symptoms?** ☐ Yes ☐ No
14. **Do you have difficulty with bowel or bladder control?** ☐ No ☐ Yes; since______________
15. **Have you missed work because of your symptoms?** ☐ No ☐ Yes; how much time ________
16. **Previous treatments for my condition have included**: (check any boxes that apply)
    - ☐ **Nothing** (no medicines, therapy, manipulations, injections, or braces)
    - ☐ Physical therapy: did it help relieve your symptoms?_______________
    - ☐ Chiropractic manipulation; did it help relieve your symptoms?_______________
    - ☐ Braces; did it help relieve your symptoms?_______________
    - ☐ Spine injections: How many injections have you had?_________________

      For how long did the injections relieve your pain?_______________
    - ☐ Surgery

      How many surgeries have you had on your BACK?__________________

      When was/were the surgery(ies) on your BACK?_____________________________

      Did surgery relieve your symptoms?____________________________
    - ☐ Other treatment:____
17. **Previous doctors seen for your spine problem:** ☐ None

Doctor	Specialty	City	Recommendations/Treatments

18. **List pain medications and dose taken for your spine problem**: ☐ None

Medication	Dose

Colorado Back and Spine – Dr. Anant Kumar

MEDICAL CONDITIONS THAT YOU HAVE OR HAD IN THE PAST: (check all that apply)

☐ None apply

☐ Heart attack ☐ Diabetes ☐ Lung disease ☐ Liver trouble
☐ Heart failure ☐ Stroke ☐ HIV ☐ Hepatitis
☐ High blood pressure ☐ Seizures ☐ AIDS ☐ Thyroid trouble
☐ Osteoarthritis ☐ Mental illness ☐ Tuberculosis ☐ Bleeding disorders
☐ Rheumatoid arthritis ☐ Kidney stones ☐ Asthma ☐ Anemia
☐ Ankylosing spondylitis ☐ Kidney failure ☐ Blood clot in LEG ☐ Blood clot in lung
☐ Gout ☐ Stomach ulcers ☐ Alcoholism ☐ Drug use
☐ Osteoporosis
☐ Cancer (type)______________________________
☐ Serious injuries (explain) ____
☐ Other (explain)____

MEDICATIONS YOU TAKE (please list): ☐ None

____
____
____
____
____

ARE YOU ALLERGIC TO ANY MEDICINE? ☐ No known drug allergies

Medication Reaction

______________________________ _______________
______________________________ _______________
______________________________ _______________

Are you allergic to latex? ☐ Yes ☐ No
Have you had complications with anesthesia? ☐ Yes ☐ No

PAST SURGICAL HISTORY
Please list previous surgeries, surgeon and date. ☐ None

OPERATION	SURGEON	DATE

FAMILY HISTORY: (check all that apply)

☐ None apply
☐ Scoliosis ☐ Spine problems ☐ Arthritis ☐ Mental illness ☐ Alcoholism
☐ Heart trouble ☐ Stroke ☐ High blood pressure ☐ Diabetes ☐ Seizures
☐ Cancer ☐ Bleeding disorders ☐ Blood clots ☐ Other _____________

Colorado Back and Spine – Dr. Anant Kumar

SOCIAL HISTORY: (check all that apply)

1. Work status: ☐ Working: __Full time __ Part time ☐ Retired ☐ Disabled ☐ Unemployed
   Occupation:____
2. Marital status: ☐ Married ☐ Single ☐ Co-habitating ☐Widowed ☐ Divorced
3. I live: ☐ Alone ☐ With:____________________________
4. Number of living children:____________
5. Tobacco and nicotine use: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe
   ☐ Cigarettes __________ packs per day for ________ years.
   ☐ Quit – When?____________after smoking_______ packs per day for _______ years
6. Alcohol intake: ☐ Never ☐ <2 drinks/month ☐ 1-2 drinks/week ☐ 1-2 drinks/day
7. Drug use: ☐ Never ☐ Currently ☐ In the past
8. If you have scoliosis how old were you when you started your menstrual cycle?__________
9. Because of my spine problem, I have filed or plan to file:
   ☐ A lawsuit ☐ A Worker's Compensation claim ☐ Neither

REVIEW OF SYSTEMS: (check all that apply)

Constitutional	☐ None apply ☐ Recent weight change ☐ Poor appetite ☐ Hot or cold spells ☐ Fever or chills
Eyes	☐ None apply ☐ Change of vision ☐ Reading glasses
Cardiac	☐ None apply ☐ Abnormal heartbeat ☐ Heart or chest pain ☐ Swollen ankles
Respiratory	☐ None apply ☐ Shortness of breath ☐ Morning cough
Gastrointestinal	☐ None apply ☐ Frequent Constipation ☐ Frequent diarrhea ☐ Stomach pain ☐Ulcers ☐ Nausea or vomiting
Genitourinary	☐ None apply ☐ Frequent urination ☐ Burning with urination ☐ Difficulty starting urination
Neurologic	☐ None apply ☐ Frequent headaches ☐ Blackouts ☐ Seizures ☐ Weakness ☐ Numbness
Skin	☐ None apply ☐ Frequent rash ☐ Acne
ENMT	☐ None apply ☐ Gum trouble ☐ Toothache ☐ Loss of hearing ☐ Cavities ☐ Missing teeth ☐ Dentures ☐ Ear pain/infection ☐ Nosebleeds ☐ Hoarseness ☐ Difficulty swallowing
Heme/Lymph	☐ None apply ☐ Anemia ☐ Blood clots☐ Easily bruising ☐ Bleeding disorder
Psychiatric	☐ None apply ☐ Depression ☐ Schizophrenia ☐ Bipolar disorder ☐ Alcoholism ☐ Drug abuse

Patient Signature ______________________________Date ____________________

Physician Signature ____________________________Date ____________________

Colorado Back and Spine – Dr. Anant Kumar

Physical Examination (**FOR OFFICE USE ONLY** – Patients continue to the next page)

1. Constitutional:
   a. Vital Signs: Height ________Weight______Pulse_______Resp________
   b. Appearance: Nutrition______Habitus______Deformity______Grooming__________
2. Neurological
   a. Orientation (PERSON/PLACE/TIME) Mood/ Affect (depression, anxiety, agitation)
3. SKIN (scars, ulcerations, etc; location); Neck________Back________BUE________BLE____________
4. Adams forward bend: PT___________ MT____________ TL/L______________
5. Pain Range of Motion Cervical/Thoracolumbar Spine (Yes/No)_______________________________
6. Pain palpation Cervical/Thoracolumbar Spine (Yes/No; Location)___________________________
7. GAIT: Tandem gait: (steady / unsteady); Able to Heel walk: (+ / -); Able to Toe walk:(+ / -)
8. Motor: Delt Bi Tri WE WF FF INT Psoas Quad DF EHL PF INV EVER
   R
   L
9. Sensation: (symmetric, deficits, region of deficit):
10. DTR: Biceps Triceps BR Knee Ankles Babinski Hoffman's Clonus Umbilicus
    R
    L
11. Cardiovascular: DP PT Vascular changes Swelling
    R
    L

Straight LEG raise	
Femoral Stretch Test	
Pain hip ROM	
Pain knee ROM	
Pain Shoulder ROM	
Coordination	
SI pain	
Rhomberg	
Carpal/Cubital tunnel exam	

Lab/EMG Results:
Exam type Date obtained Findings

Diagnostic Imaging

Exam type Date obtained Findings

Assessment ________________________________
Recommendations: Prescription Drug (mod-mgmt)________Physical Therapy (low-mgmt) Injections (high DxP) Surgery (high)

Colorado Back and Spine – Dr. Anant Kumar

Modified Oswestry Low Back Pain Disability Questionnaire[a]

This questionnaire has been designed to give your doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, **but please mark ONLY the box that most closely describes your current condition.**

[a]Modified by permission of The Chartered Society of Physiotherapy from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy* 1980;66:271-273.

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication
- ☐ The pain is bad, but I can manage without having to take pain medication
- ☐ Pain medication provides me with complete relief from pain
- ☐ Pain medication provides me with moderate relief from pain
- ☐ Pain medication provides me with little relief from pain
- ☐ Pain medication has no effect on my pain

Personal Care (e.g., Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain
- ☐ I can take care of myself normally, but it increases my pain
- ☐ It is painful to take care of myself and I am slow and careful
- ☐ I need help, but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Lifting
- ☐ I can lift heavy weights without increased pain
- ☐ I can lift heavy weights but it gives increased pain
- ☐ 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)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Walking
- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile
- ☐ I can only walk with crutches or a cane
- ☐ I am in bed most of the time and have to crawl to the toilet

Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than ½ hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ Pain prevents me from sitting at all

Standing
- ☐ I can stand as long as I want without increased pain
- ☐ I can stand as long as I want, but it increases my pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than ½ hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Sleeping
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using pain medication
- ☐ Even when I take pain medication, I sleep less than 6 hours
- ☐ Even when I take pain medication, I sleep less than 4 hours
- ☐ Even when I take pain medication, I sleep less than 2 hours
- ☐ Pain prevents me from sleeping at all

Social Life
- ☐ My social life is normal and does not increase my pain
- ☐ My social life is normal, but it increases my level of pain
- ☐ Pain prevents me from participating in more energetic activities (e.g., sports, dancing)
- ☐ Pain prevents me from going out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of my pain

Traveling

- ☐ I can travel anywhere without increased pain
- ☐ I can travel anywhere, but it increases my pain
- ☐ My pain restricts my travel over 2 hours
- ☐ My pain restricts my travel over 1 hour
- ☐ My pain restricts my travel to short necessary journeys under ½ hour
- ☐ My pain prevents all travel except for visits to the physician/therapist or hospital

Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties
- ☐ Pain prevents me from doing even light duties
- ☐ Pain prevents me from performing any job or homemaking chores

____

Patient Signature

____

Date

Zurich Claudication Questionnaire

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

Symptom Severity Scale

1. The pain you have had on average including the pain in your back, buttocks and pain that goes down you legs:

- ☐ Very Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ None

2. How often have you had back, buttock, or leg pain?

- ☐ Every minute of the day
- ☐ Everyday for most of the day
- ☐ Everyday, for at least a few minutes
- ☐ At least once a week
- ☐ Less than once a week

3. The pain in your back or buttocks?

- ☐ Very Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ None

4. The pain in your legs or feet?

- ☐ Very Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ None

5. Numbness or tingling in your legs or feet?

- ☐ Very Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ None

6. Weakness in your legs or feet?

- ☐ Very Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ None

7. Problems with your balance?

- ☐ Yes, often I feel my balance is off, or that I'm not sure footed
- ☐ Yes, sometimes I feel my balance is off, or that I'm not sure footed
- ☐ No, I have had no problems with balance

Physical Function Scale

8. How far have you been able to walk?

- ☐ Less than 50 feet
- ☐ Over 50 feet, but less than 2 blocks
- ☐ Over 2 blocks, but less than 2 miles
- ☐ Over 2 miles

9. Have you taken walks outdoors or in malls?

- ☐ No
- ☐ Yes, but always with pain
- ☐ Yes, but sometimes with pain
- ☐ Yes, comfortably

10. Have you been shopping for groceries other items?

- ☐ No
- ☐ Yes, but always with pain
- ☐ Yes, but sometimes with pain
- ☐ Yes, comfortably

11. Have you walked around the different rooms in your house or apartment?

- ☐ No
- ☐ Yes, but always with pain
- ☐ Yes, but sometimes with pain
- ☐ Yes, comfortably

12. Have you walked from your bedroom to the bathroom?

☐ No
☐ Yes, but always with pain
☐ Yes, but sometimes with pain
☐ Yes, comfortably

____

Patient Signature

____

Date

Scoliosis Patient Questionnaire:
Version 30 (Encompasses Versions 22 and 24)

Modified 06/11/13

Patient Name:______________________________**Age:**_______**Date:**_______________

Medical Record #: ______________________________ **Sex:** _______________

Exam: Pre-treatment 3 mos. 6 mos. 1 year _______ years

Your doctors are carefully evaluating the condition of your back before and after your treatment. Please circle the one best answer to each question unless otherwise indicated. If you already have had surgery, please complete **sections 1 and 2.** Otherwise, just complete section **1.**

All results will be kept confidential.

Section 1: All Patients

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
22:1
24:1
- ☐ None 5
- ☐ Mild 4
- ☐ Moderate 3
- ☐ Moderate to severe 2
- ☐ Severe 1

2. Which one of the following best describes the amount of pain you have experienced over the last month?
22:2
24:2
- ☐ None 5
- ☐ Mild 4
- ☐ Moderate 3
- ☐ Moderate to severe 2
- ☐ Severe 1

3. During the past 6 months have you been a very nervous person?
22:3
24:n/a
- ☐ None of the time 5
- ☐ A little of the time 4
- ☐ Some of the time 3
- ☐ Most of the time 2
- ☐ All of the time 1

4. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?
22:4
24:3
- ☐ Very happy 5
- ☐ Somewhat happy 4
- ☐ Neither happy nor unhappy 3
- ☐ Somewhat unhappy 2
- ☐ Very unhappy 1

5. What is your current level of activity?
22:5
24:4
- ☐ Bedridden/wheelchair 1
- ☐ Primarily no activity 2
- ☐ Light labor, such as household chores 3
- ☐ Moderate manual labor and moderate sports, such as walking and biking 4
- ☐ Full activities without restriction 5

6. How do you look in clothes?
22:6
24:5
- ☐ Very good 5
- ☐ Good 4
- ☐ Fair 3
- ☐ Bad 2
- ☐ Very bad 1

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
22:7
24:n/a
- ☐ Very often 1
- ☐ Often 2
- ☐ Sometimes 3
- ☐ Rarely 4
- ☐ Never 5

8. Do you experience back pain when at rest?
22:8
24:6
- ☐ Very often 1
- ☐ Often 2
- ☐ Sometimes 3
- ☐ Rarely 4
- ☐ Never 5

9. What is your current level of work/school activity?
22:9
24:7
- ☐ 100% normal 5
- ☐ 75% normal 4
- ☐ 50% normal 3
- ☐ 25% normal 2
- ☐ 0% normal 1

10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
22:10
24:n/a
- ☐ Very good 5
- ☐ Good 4
- ☐ Fair 3
- ☐ Poor 2
- ☐ Very poor 1

11. Which one of the following best describes your medication usage for your back?
22:11
24:8
- ☐ None 5
- ☐ Non-narcotics weekly or less (e.g., Tylenol, Ibuprofen) 4
- ☐ Non-narcotics daily 3
- ☐ Narcotics weekly or less (e.g., Tylenol #3, Lorocet, Percocet, Darvocet) 2
- ☐ Narcotics daily 1
- ☐ Other *(please specify below)*

Medication:
____

Usage (weekly or less or daily):
____

12. Does your back limit your ability to do things around the house?
22:12
24:9
- ☐ Never 5
- ☐ Rarely 4
- ☐ Sometimes 3
- ☐ Often 2
- ☐ Very often 1

13. Have you felt calm and peaceful during the past 6 months?
22:13
24:n/a
- ☐ All of the time 5
- ☐ Most of the time 4
- ☐ Some of the time 3
- ☐ A little of the time 2
- ☐ None of the time 1

14. Do you feel that your back condition affects your personal relationships?
22:14
24:11
- ☐ None 5
- ☐ Slightly 4
- ☐ Mildly 3
- ☐ Moderately 2
- ☐ Severely 1

15. Are you and/or your family experiencing financial difficulties because of your back?
22:15
24:12
- ☐ Severely 1
- ☐ Moderately 2
- ☐ Mildly 3
- ☐ Slightly 4
- ☐ None 5

16. In the past 6 months have you felt down-hearted and blue?
22:16
24:n/a
- ☐ Never 5
- ☐ Rarely 4
- ☐ Sometimes 3
- ☐ Often 2
- ☐ Very often 1

17. In the last 3 months have you taken any sick days from work/school due to back pain and, if so, how many?
22:17
24:10

☐ 0 5 ☐ 1 4 ☐ 2 3 ☐ 3 2 ☐ 4 or more 1

18. Do you go out more or less than your friends?
22:18
24:13
- ☐ Much More 5
- ☐ More 4
- ☐ Same 3
- ☐ Less 2
- ☐ Much less 1

19. Do you feel attractive with your current back condition?
22:19
24:14
- ☐ Yes, very 5
- ☐ Yes, somewhat 4
- ☐ Neither attractive nor unattractive 3
- ☐ No, not very much 2
- ☐ No, not at all 1

20. Have you been a happy person during the past 6 months?
22:20
24:n/a
- ☐ None of the time 1
- ☐ A little of the time 2
- ☐ Some of the time 3
- ☐ Most of the time 4
- ☐ All of the time 5

21. Are you satisfied with the results of your back management?
22:n/a
24:15
- ☐ Very satisfied 5
- ☐ Satisfied 4
- ☐ Neither satisfied nor unsatisfied 3
- ☐ Unsatisfied 2
- ☐ Very unsatisfied 1

22. Would you have the same management again if you had the same condition?
22:21
24:15
- ☐ Definitely yes 5
- ☐ Probably yes 4
- ☐ Not sure 3
- ☐ Probably not 2
- ☐ Definitely not 1

23. On a scale of 1 to 9, with 1 being very low and 9 being extremely high, how would you rate your self-image?
22:22
24:24

☐ 1 ☐ 2	☐ 3 ☐ 4	☐ 5	☐ 6 ☐ 7	☐ 8 ☐ 9
1	2	3	4	5

Section 2: Post-surgery patients only

24. Compared with before treatment, how do you feel you now look?
22:n/a
24:23
- ☐ Much Better 5
- ☐ Better 4
- ☐ Same 3
- ☐ Worse 2
- ☐ Much Worse 1

25. Has your back treatment changed your function and daily activity?
22:n/a
24:16

☐ Increased 5 ☐ Not changed 3 ☐ Decreased 1

26. Has your back treatment changed your ability to enjoy sports/hobbies?
22:n/a
24:17

☐ Increased 5 ☐ Not changed 3 ☐ Decreased 1

27. Has your back treatment ________________ your back pain?
22:n/a
24:18

☐ Increased 1 ☐ Not changed 3 ☐ Decreased 5

28. Has your treatment changed your confidence in personal relationships with others?
22:n/a
24:19

☐ Increased 5 ☐ Not changed 3 ☐ Decreased 1

29. Has your treatment changed the way others view you?
22:n/a
24:20
- ☐ Much Better 5
- ☐ Better 4
- ☐ Same 3
- ☐ Worse 2
- ☐ Much Worse 1

30. Has your treatment changed your self-image?
22:n/a
24:21

☐ Increased 5 ☐ Not changed 3 ☐ Decreased 1

SRS-30 Patient Questionnaire/Score Sheet

Name: ______________________________ Today's Date: ______________
Mo Day Year

Age: _____ _____
Yr Mo

Sex: M F

Diagnoses: ______________________

Deformity/Size__________ __________

Management: (Circle one)
- Initial Evaluation
- Observation
- Pre Brace
- Brace______________ (Type)
- Other______________ (Describe)

Pre Surgery Indication______________

	Arthrodesis UV	Arthrodesis LV	Instrumentation UV	Instrumentation LV
Surgery				
Post	___		___	
Ant	___		___	

Date Initiated: ____ ____ ____ / ____ ____ ____ / Mo Day Yr

Follow-up ____ ____ / ____ / Yrs Mo

DOMAIN	(Score: 5 Best – 1 Worst)	Post Surgery Questions	Score Pt/Possible(Max) **A**	#Questions Answered(Possible) **B**	Mean Score *** **A÷B**
Function/ Activity	5* 9 12 15 18	25 26	___(__)(25) (35)+	___(5) (7)+	___
Pain	1 2 8 11 17	27	___(__)(25) (30)	___(5) (6)	___
Self Image/ appearance	4 6 10 14 19 23	28 29 30	___(__)(30) (45)	___(6) (9)	___
Mental health**	3 7 13 16 20		___(__)(25)	___(5)	___
SUB TOTAL			___(__)(105) (135)	___(21) (27)	___
Satisfaction with management	21 22	24	___(__)(10) (15)	___(2) (3)	___
TOTAL			___(__)(115) (150)	___(23) (30)	___

+max/possible with post surgery questions

***Mean Score 5 Best 1 Worst

*Question Number
**Questions adopted with permission from SF-36

SCORING INSTRUCTIONS
Unanswered questions – reduce questions answered denominator by appropriate number
Delete questions with more than one response
Domain can't be scored if fewer than 3 questions answered

G:\SRS\Outcomes\SRS 30\30 score sheet.doc

06/11/2013