Dear Patient,

We are pleased to welcome you to Southwest Florida Pain Center.

We ask that you please arrive 15 minutes prior to your appointment and bring the following documents:

- **Driver's License/ID card**
- **Insurance card(s)**
- **Completed new patient paperwork (*Please use blue or black ink only.*)**

At your initial visit we will have you complete a pain assessment chart. You will then be examined by a physician and a treatment plan will be developed and discussed with you. Please be advised some insurances require pre-authorization prior to a procedure.

Please feel free to call us at (941) 627-9095, if you have any questions.

We look forward to meeting you.

Sincerely,

SW Florida Pain Center Staff

PATIENT INFORMATION

Patient Name: ____ Date: __________________________
Last First M. (preferred name)

Home Address: ____ _____ Birth Date: _____ /_____ /_____

Gender: ☐ Male ☐Female Marital Status: _______________ Social Security # _________________________

Primary Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian
☐ Native Hawaiian or other Pacific Islander ☐ Hispanic ☐ Decline to provide this info

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide this info

Driver's License # ________________________________ Email Address: __________________________

Phone (Home): ___________________ (Work): _____________________ (Cell): ______________________

Employer Name: __________________________________ Occupation: ______________________________

Employer Address: ____ Phone:_____________________

In case of emergency contact: ____ Phone:_____________________

How did you hear about our office? __________________ Primary Care Physician: ________________________

Primary Insurance	Secondary Insurance (if applicable)
Insurance Name: ______________________________	Insurance Name: ______________________________
Insurance Address: ____________________________	Insurance Address: ____________________________
Insurance Phone # ____________________________	Insurance Phone # ____________________________
Group # ______________ Policy # ________________	Group # ______________ Policy # ________________
Insured's Name ________________ Relation: ____________	Insured's Name ________________ Relation: ____________
Insured's Birth date ____ /_____ / _____ Insured's SS# __________	Insured's Birth date ____ / ____ /____ Insured's SS# ____________
Insured's Employer: ___________________________	Insured's Employer: ___________________________

Workers' Compensation, Auto Billing Information

Insurance Carrier Name: ______________________________________ Phone # _______________________________

Address: ____ Claim # ___________________ Date of Accident: ____________

Adjuster:___________________________________ Phone #________________________ Fax # __________________________

Nurse Case Mgr: __________________________________ Phone #_____________________ Fax # ________________________

Attorney: ____ Phone #_____________________ Fax # ________________________

Address: ____

I certify that the information I have reported is correct.

____ ______________________________
Patient Signature Date

HIPAA OMINIBUS RULE for

SW Florida Pain Center

PATIENT ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: ________________________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

___________________________________ ___________________________________

Please ***print*** your name Please ***sign*** your name

___________________________________ ___________________________________

Parent/Guardian Description of Authority

Your comments regarding Acknowledgements or Consents:

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?
☐First Name Only ☐Proper Surname ☐Other __________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents, and any care takers who can have access to this patient's records)

Name: _________________________________ Relationship: ___________________________

Name: _________________________________ Relationship: ___________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM **MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
____ It was emergency treatment
____ I could not communicate with the patient
____ The Patient refused to sign
____ The patient was unable to sign because ____________________________
____ Other (please describe) ____ ____

Signature of Privacy Officer

Southwest Florida Pain Center
SPINAL DIAGNOSTICS & NEUROMODULATION

FINANCIAL POLICY

We are dedicated to you, our patient, and our goal is to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful; therefore, we are providing you with information to clarify your financial responsibility.

- ☐ Our **Consent Form** must be updated yearly. This form allows us to submit medical claims for services provided to you to your insurance company, as well as appeal improperly paid claims. *Refusal to sign this form will result in you being considered a self-pay. You will then be responsible for our entire billed amounts.*

- ☐ Your personal information (address, phone number, etc.) must be updated whenever there is a change, as well as, your insurance information. You will be asked to produce a picture ID, as well as, proof of insurance. SW Florida Pain Center will verify coverage prior to services being provided. We rely on the information you provide in order to bill third parties for your medical services**. Balances that are not paid due to errors or omission in the information you provide may result in the entire balance becoming your responsibility.** Please be sure to report all potential third party sources of payment (auto, work comp, supplemental, etc.)

- ☐ Most insurance policies require patient co-pay for office services. *Payment of your office co-pay is required at the time of service.*

- ☐ We accept cash, check and all major credit cards. Your check may be converted to a one-time electronic debit from your checking account. A $25 fee will be assessed on any checks returned for insufficient funds.

- ☐ If a procedure/treatment is indicated, our billing department will provide you with an estimate for our physicians' services. Most policies require a patient co-insurance until your deductible and out-of-pocket requirements have been met. *Payment of the estimated co-insurance is required prior to the procedure.*

- ☐ If you are a self-pay, payment in full is expected at the time of service.

- ☐ SW Florida Pain Center is contracted with many insurance networks. If you are unsure if we participate with your insurance, please ask to speak with someone in our billing department or contact your insurance company's member services.

- ☐ SW Florida Pain Center may not be a participating provider with your insurance company. Your insurance company may send payment for SW Florida Pain Center services directly to you. By signing our **Consent Form**, you agree that it is your financial responsibility to forward any payment received to this office. Failure to send us payments you have received from your insurance company for services provided by SW Florida Pain Center may result in your account being turned over to collections.

- ☐ We impose a $50.00 no-show/late cancellation fee. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of health care to other patients, most of who are in severe pain. A "no show" is missing a scheduled appointment. A "late cancellation" is cancelling an appointment without calling us to cancel 24 hours in advance of the appointment. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Southwest Florida Pain Center
SPINAL DIAGNOSTICS & NEUROMODULATION

CONSENT FOR TREATMENT

I give permission to the physicians and staff of SW Florida Pain Center ("the practice") to administer or perform medical treatment. I acknowledge that risks, if any, will be explained to me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. The practice may also use my Protected Health Information (PHI) to treat me or to disclose to other healthcare providers, such as my referring physician or primary care physician, for purposes related to my treatment.

____ ______________________
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _________________________________

CONSENT TO RELEASE INFORMATION

I consent that the practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per federal and state regulations. The practice may use or disclose my PHI internally or disclose my PHI to healthcare providers and entities as necessary to operate their business. The practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment option or alternatives. The practice may use and disclose my PHI to advise a friend or family member that is involved in my care or assists in taking care of me. My PHI may also be used and disclosed when federal, state or local law requires. The practice may share my PHI with third party "Business Associates" that perform activities on their behalf such as billing software maintenance.

____ ______________________
Signature of Patient or Legal Representative Date

FINANCIAL CONSENT

I hereby authorize direct remittance of payment of insurance benefits to the practice for all covered medical services rendered. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated by the practice and will constitute a continuing authorization, maintained on file with the practice for subsequent and continuing treatment, services, and/or supplies provided to me by the practice. The practice my use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections I accept legal responsibility for charges that my insurance company does not cover and will pay for them at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the practice may not be a participating provider with my insurance company. Should I receive payment directly from the insurance company, I agree to forward the check and "Explanation of Benefits" to the practice within 10 days of receipt. If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

____ ______________________
Signature of Patient or Legal Representative Date

WRITTEN ACKNOWLEGMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of SW Florida Pain Center's Notice of Privacy Practices that describes how my health information is used and shared. I understand that the practice has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at the physician's office.

____ ______________________
Signature of Patient or Legal Representative Date

PATIENT INFORMATION FORM

Please complete prior to the examination in BLACK/BLUE INK ONLY

Today's Date: ________________________ Patient's Name_______________________________________

Height ________________ Patient's Phone #: ___________________________________

Weight ________________ Patient's Age: _________________

Referred by: ____

Primary Care Physician: _______________________________________Phone #:____________________________________

Are you employed? ☐ Yes ☐ No

Are you currently on disability? ☐ Yes ☐ No Reason: ____

Workman's Compensation: ☐ Yes ☐ No

Involved in Pending Litigation: ☐ Yes ☐ No Lawyer's Name/Phone: ____

PAIN HISTORY

Where is the location of your pain? ____

____

When and under what circumstances did the pain begin?

- ☐ Accident at work or home
- ☐ Following a surgery
- ☐ Motor vehicle accident
- ☐ Following an illness
- ☐ Other (describe details) ____

What increases the pain? ____

What decreases the pain? ____

What time of the day is your pain worst? ________________________________What is your pain score? (0 – 10) ________________

What time of the day is less severe? ____________________________________What is your pain score? (0 – 10) ________________

What statement best describes your pain? ☑ **Choose only one**

- ☐ Always present, always the same intensity
- ☐ Always present, intensity varies
- ☐ Usually present, but has short periods from one to several hours
- ☐ Occasionally present for a brief period of time

Does pain interrupt your sleep? ☐ Yes ☐ No If yes, how often during the night does it wake you up? ___________________

WHAT DOES YOUR PAIN FEEL LIKE?

Some of the words below describe your present pain. Look through these categories. CIRCLE ONE SINGLE WORD IN EACH CATEGORY that best describes your pain. Leave out any category that is not suitable.

Flickering Quivering Pulsing Throbbing Beating Pounding	Jumping Flashing Shooting	Pricking Boring Drilling Stabbing Lancinating	Sharp Cutting Lacerating	Spreading Radiating Penetrating Piercing	Fearful Frightful Terrifying	Annoying Troublesome Miserable Intense Unbearable
Pinching Pressing Gnawing Cramping Crushing	Tugging Pulling Wrenching	Hot Burning Scalding Searing	Tingling Itchy Smarting Stinging	Tight Numb Drawing Squeezing Tearing	Punishing Grueling Cruel Vicious Killing	Nagging Nauseating Agonizing Dreadful Torturing

MEDICAL HISTORY

Circle YES or NO

YES	**NO**	Heart Attack	**YES**	**NO**	Diabetes
YES	**NO**	Angina	**YES**	**NO**	Thyroid Disease
YES	**NO**	Irregular heart beat	**YES**	**NO**	Hepatitis / Jaundice
YES	**NO**	Heart murmur	**YES**	**NO**	Ulcers, other stomach problems
YES	**NO**	High / Low Blood pressure	**YES**	**NO**	Kidney Disease
YES	**NO**	Fainting Episodes	**YES**	**NO**	Glaucoma
YES	**NO**	Congestive heart failure	**YES**	**NO**	Bleeding Problems
YES	**NO**	Shortness of Breath/ Lung Disease	**YES**	**NO**	Liver Disease
YES	**NO**	Emphysema / Bronchitis	**YES**	**NO**	Hearing Problems
YES	**NO**	Asthma	**YES**	**NO**	Cancer
YES	**NO**	Recent Upper Respiratory Infection	**YES**	**NO**	Joint disease / Arthritis
YES	**NO**	Seizures, Epilepsy	**YES**	**NO**	Bladder Problems
YES	**NO**	Stroke	**YES**	**NO**	Visual Problems
YES	**NO**	Depression, mental health problems	**YES**	**NO**	Bowel Problems
YES	**NO**	Headaches	**YES**	**NO**	Dermatological conditions
YES	**NO**	Neurological problems	**YES**	**NO**	Are you pregnant?
YES	**NO**	MRSA	**YES**	**NO**	Hepatitis or Autoimmune disease

Explanation/Other: ____

SURGICAL HISTORY

TYPE OF SURGERY	DATE

TREATMENT HISTORY:

TREATMENT	YES	NO	HELPFUL / COMPLICATIONS	COMMENTS
Traction				
TENS Unit				
Physical Therapy				
Biofeedback				
Hypnosis				
Counseling				
Chiropractor				
Acupuncture				
Osteopathic TX				
Heat / Ice				
Occupational Therapy				
Nerve Blocks				

INVESTIGATIONS: (TEST TO EVALUATE YOUR PAIN PROBLEM)

TEST	YES	NO	DATE	WHERE / FINDINGS
XRAY				
CT SCAN / MRI				
EMG				
MYELOGRAM				
EPIDUROGRAM				
LAB TESTS				
OTHER:				

MEDICATIONS: (PRESCRIPTION AND OVER THE COUNTER)

MEDICATION	DOSAGE	TIMES A DAY

ALLERGIES: ______________________________

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If yes, how many a day? ______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, what type of alcohol and how much a day? ______________________________

Do you currently or have you ever taken or used illegal drugs or substances? ☐ Yes ☐ No

Do you have a history of drug or alcohol rehabilitation? ☐ Yes ☐ No

Were there any changes in your life during the year before this pain began? (i.e. job change, buying or selling a house, death or loss of a friend/relative, marital problems): ______________________________

____

FAMILY HISTORY:

	AGE	HEART DISEASE	CANCER	T.B.	DIABETES	AGE AT DEATH	CAUSE OF DEATH
Father		Yes No	Yes No	Yes No	Yes No		
Mother		Yes No	Yes No	Yes No	Yes No		
Sister (s)		Yes No	Yes No	Yes No	Yes No		
Brother (s)		Yes No	Yes No	Yes No	Yes No		

What are your expectations of this pain center? ______________________________

Have you ever gone to another pain management physician or center? ☐ Yes ☐ No

Whom, where & when? ______________________________

Reason for leaving ______________________________

SOAPP® VERSION 1.0 SP

The following are questions given to all patients. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

1. How often do you have mood swings? 0 1 2 3 4

2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

3. How often have you taken medication other than the way it was prescribed? 0 1 2 3 4

4. How often have you used illegal drugs (for example: Marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

5. How often, in your lifetime, have you had legal Problems or been arrested? 0 1 2 3 4

______________________________ ______________________________

Patient Signature Date

REVIEW OF SYSTEMS

- **CONSTITUTIONAL SYMPTOMS**

Good general health lately ☐ No ☐ Yes
Recent weight change... ____increase ____decrease ☐ No ☐ Yes
Fever ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes

- **EYES**

Eye disease or injury ☐ No ☐ Yes
Wear glasses/contact lens ☐ No ☐ Yes
Blurred or double vision ☐ No ☐ Yes
Glaucoma ☐ No ☐ Yes

- **EARS/NOSE/MOUTH/THROAT**

Hearing loss ☐ No ☐ Yes
Ringing in ears ☐ No ☐ Yes
Ear aches or drainage ☐ No ☐ Yes
Chronic sinus problem or rhinitis ☐ No ☐ Yes
Nose bleeds ☐ No ☐ Yes
Sore throat ☐ No ☐ Yes
Voice change ☐ No ☐ Yes
Swollen glands ☐ No ☐ Yes

- **CARDIOVASCULAR**

Heart trouble ☐ No ☐ Yes
Chest pain or angina pectoris ☐ No ☐ Yes
Palpitation ☐ No ☐ Yes
Shortness of breath with walking or lying flat ☐ No ☐ Yes
Swelling of feet or ankles ☐ No ☐ Yes
Atrial fibrillation ☐ No ☐ Yes
Heart valve disease ☐ No ☐ Yes
Pacemaker ☐ No ☐ Yes
AICD ☐ No ☐ Yes

- **RESPIRATORY**

Chronic or frequent coughs ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Asthma or wheezing ☐ No ☐ Yes
COPD ☐ No ☐ Yes

- **GASTROINTESTINAL**

Loss of appetite ☐ No ☐ Yes
Nausea or vomiting ☐ No ☐ Yes
Diarrhea ☐ No ☐ Yes
Constipation ☐ No ☐ Yes
Abdominal pain ☐ No ☐ Yes
Heartburn ☐ No ☐ Yes
GERD ☐ No ☐ Yes

- **GENITOURINARY**

Frequent urination ☐ No ☐ Yes
Change in force of strain when urinating ☐ No ☐ Yes
Incontinence or dribbling ☐ No ☐ Yes
Kidney stones ☐ No ☐ Yes
Hx Kidney failure ☐ No ☐ Yes

- **MUSCULOSKELETAL**

Joint pain ☐ No ☐ Yes
Joint swelling ☐ No ☐ Yes
Weakness of muscles ☐ No ☐ Yes
Muscle pain ☐ No ☐ Yes
Back pain ☐ No ☐ Yes
Neck pain ☐ No ☐ Yes

- **INTEGUMENTARY (skin, breast)**

Rash ☐ No ☐ Yes
Itching ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes
Breast pain ☐ No ☐ Yes
Breast lump ☐ No ☐ Yes
Breast discharge ☐ No ☐ Yes

- **NEUROLOGICAL**

Frequent or recurring headaches ☐ No ☐ Yes
Light headed ☐ No ☐ Yes
Dizzy ☐ No ☐ Yes
Convulsions or seizures ☐ No ☐ Yes
Numbness or tingling sensations ☐ No ☐ Yes
Tremors ☐ No ☐ Yes
Paralysis ☐ No ☐ Yes
Stroke ☐ No ☐ Yes
Head injury ☐ No ☐ Yes
Difficulty in Walking ☐ No ☐ Yes
Memory loss or confusion ☐ No ☐ Yes

- **PSYCHIATRIC**

Nervousness ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Insomnia ☐ No ☐ Yes

- **ENDOCRINE**

Glandular or hormone problem ☐ No ☐ Yes
Excessive thirst or drinking ☐ No ☐ Yes
Diabetes ☐ No ☐ Yes
Change in hat or glove size ☐ No ☐ Yes

- **HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts ☐ No ☐ Yes
Bleeding or bruising tendency ☐ No ☐ Yes
Anemia ☐ No ☐ Yes
Phlebitis ☐ No ☐ Yes
Past transfusion ☐ No ☐ Yes

- **ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ☐ No ☐ Yes
Morphine, Demerol, or other narcotics ☐ No ☐ Yes
Novocaine or other anesthetics ☐ No ☐ Yes
Aspirin or other pain remedies ☐ No ☐ Yes
Tetanus antitoxin or other serums ☐ No ☐ Yes
Iodine, methiolate or other antiseptic ☐ No ☐ Yes
Other drugs/medications ________________
Known food allergies ________________

Patient Name: ________________

Oswestry Disability Index

Patient name: ____ **Date**: _________________________

Please complete this questionnaire. It is designed to tell us how your back pain affects your ability to function in everyday life.

Please answer each section below by checking the one choice that applies the most to you at this time. You may feel that more than one of the statement relates to you at this time, but is very important that you please check only once choice that best describes your problem at this time.

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**

____ 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 every day in most aspects of self care.
____ I do not get dressed, wash with difficulty and stay in bed

SECTION 3: **Lifting**

____ I can lift heavy weights without extra pain
____ I can lift heavy weights but it causes extra 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

SECTION 4: **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 1/4 mile
____ Pain prevents me from walking more than 100 yards
____ I can walk only with crutches or a stick
____ I am in bed most of the time and have to crawl to the toilet

SECTION 5: **Sitting**

____ I can sit in any chair as long as I like
____ I can sit in my favorite chair for as long as I like
____ Pain prevents me from sitting for more than 1 hour
____ Pain prevents me from sitting for more than 1/2 hour
____ Pain prevents me from sitting for more than 10 minutes
____ Pain prevents me from sitting at all

SECTION 6: **Standing**

____ I can stand as long as I want without extra pain
____ I have some pain on standing, but it gives me extra pain
____ Pain prevents me from standing for more than 1 hour
____ Pain prevents me from standing for more than 1/2 an hour
____ Pain prevents me from standing for more than 10 minutes
____ 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 have less than 6 hours sleep
____ Because of pain I have less than 4 hours sleep
____ Because of pain I have less than 2 hours sleep
____ Pain prevents me from sleeping at all

SECTION 8: **Sex Life**

____ 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, dancing)
____ 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 my pain

SECTION 10: **Traveling**

____ I can travel anywhere without pain
____ I can travel anywhere, but it gives me extra pain
____ Pain is bad but I manage journeys of over 2 hours
____ Pain restricts me to journeys less than 1 hour
____ Pain restricts me to short necessary journeys under 30 minutes
____ Pain prevents me from traveling except to receive treatment

ODI score: ________%

"Point total" / 50 x 100 = percent disability

Southwest Florida Pain Center
SPINAL DIAGNOSTICS & NEUROMODULATION

Oswestry Disability Index (Cervical)

Patient name: ____ **Date**: _________________________

Please complete this questionnaire. It is designed to tell us how your pain affects your ability to function in everyday life.

Please answer each section below by checking the one choice that applies the most to you at this time. You may feel that more than one of the statement relates to you at this time, but is very important that you please check only once choice that best describes your problem at this time.

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

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

SECTION 3: Lifting

____ I can lift heavy weights without extra pain
____ I can lift heavy weights but it causes extra 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

SECTION 4: Reading

____ I can read as much as I want 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 due to moderate pain in my neck
____ I can hardly read at all because of severe pain in my neck
____ I cannot read at all

SECTION 5: Headaches

____ I have no headaches at all
____ I have slight headaches that 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 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 7: Sleeping

____ My sleep is never disturbed by pain
____ My sleep is occasionally disturbed by pain
____ Because of pain I have less than 6 hours sleep
____ Because of pain I have less than 4 hours sleep
____ Because of pain I have less than 2 hours sleep
____ Pain prevents me from sleeping at all

SECTION 8: Work

____ I can do as much work as I want to
____ I can 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 9: Driving

____ I can drive my car without any neck pain
____ I can drive my car as long as I want to 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 10: Recreation

____ I am able to engage in all my recreation activities with no neck pain at all
____ I am able to engage in all my recreation activities, with some pain in my neck
____ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
____ I am able to engage in a few of my usual recreation activities because of pain in my neck
____ I can hardly do any recreation activities because of pain in my neck
____ I cannot do any recreation activities at all

ODI score: ________%

"Point total" / 50 x 100 = percent disability

Southwest Florida Pain Center
SPINAL DIAGNOSTICS & NEUROMODULATION