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TIMOTHY J. SIEBECKER, D.P.M.

DATE: _____

Dear _____

Thank you for choosing our orthopaedic practice. This letter is a reminder of your upcoming appointment with Dr. _____ on _____ at _____.

In order to expedite the registration process, we ask you to bring the following:

1. All insurance information (Insurance cards). Also, bring Photo ID
2. If this is a Compensation injury, your Workmen's Comp Claim # and your Compensation Carrier address and phone number.
3. If Auto Accident related, your claim # and address and phone # or carrier.
4. A REFERRAL if you are a managed care participant. (Note: We are NOT allowed to see you if you do not have a referral form from your primary care physician.)
5. Please arrive 15 minutes early to complete paperwork.

We ask you to bring the actual films or copies of X-RAYS, MRI'S, BONE SCANS AND CAT SCANS AS WELL AS THEIR REPORTS, and any other pertinent test results.

If you were seen by another physician for the same problem, we ask that you hand carry any previous records, hospital records (operative reports) and any other reports (for example, nerve conduction studies, vascular studies). Please include any information regarding cortisone or epidural injections.

Enclosed is a history form (health questionnaire). Please bring the completed form with you to your appointment as well as the Authorization Form on the reverse of this page. Please bring an up to date list of your medications from your family doctor.

Payment is due at the time of service for co-payments and non-covered charges. We accept Mastercard, Visa and personal checks. If payment cannot be made at time of service, arrangements must be made with the Business Office at 307-1768 before your visit.

Directions to our office: Exit 190 off Route 81, make right, office is .3 miles on right.

Thank you for your cooperation. We look forward to meeting you.

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334 Main Street
Dickson City, PA 18519
570-307-1767

SPINE NEW PATIENT INFORMATION QUESTIONNAIRE

Name:_____ Age: _____ DOB: _____ SS# _____

Address: _____ Telephone _____

Height: _____ Weight: _____ Hand Dominance: □ right □ left □ none
Language spoken _____ Race/Ethnicity _____

Referring MD: _____Send Report? ___Family MD: _____Send Report? ___

Reason for seeing doctor: _____

Have you been treated previously for this problem? ____ Yes ____ No

If yes, where and by whom? _____

Date of Injury or when you first noticed your symptoms: _____

How did your symptoms start? □ gradually □ suddenly

Please describe the injury or events leading to the onset of your symptoms: _____

_____

_____

Please describe how your symptoms have progressed since onset: _____

_____

Please describe your symptoms as they currently affect you: _____

_____

What questions would you like to have answered during your visit?_____

_____

Please rate your pain on a scale of 1 – 10 (0=no pain, 10=worst) _____

In percentages, how much pain is in your back/neck and how much in your legs/arms?
_____ in my back/neck _____ in my legs/arms = 100%

What is the character of your pain: □ electrical □ muscle cramp □ aching □throbbing
□ dull □ sharp

SPINE QUESTIONNAIRE, PAGE 2

What makes your symptoms better? _____

What makes your symptoms worse? _____

What medicine do you *currently* take for pain? _____

During the last month, how frequently have you been taking medicine for pain?
□ 3-4 times/day □ 1-2 times/day □ once every few days □ once a week □ not at all

Describe any part of your body that is numb: _____

Describe any part of your body that is weak: _____

What does your problem limit you from doing: _____

How far can you walk comfortably? □ around the home only □ a few blocks □ under a mile
□ about a mile □ a few miles □ no limitation

Please check and *list the approximate date* of any diagnostic tests for your spine:
□ x-rays □ MRI □ EMG □ CT scan or myelogram □ bone scan
□ discogram □ Other – please specify: _____

Have you had any injections in or around your spine? □ Yes □ No
If yes, when, where, type of injection, response to injection:_____

What treatments have you tried? □ Physical therapy □ Acupuncture □ Traction
□ chiropractic care
Your response to treatment: _____

Have you had surgery on your spine? □ Yes □ No
Date: _____ Surgeon: _____ Procedure: _____
Date: _____ Surgeon: _____ Procedure: _____

Have you noticed any recent changes in your bowel or bladder function? □ Yes □ No
Is your pain worse at night? □ Yes □ No **Having fevers?** □ Yes □ No
Are you having problems with your balance? □ Yes □ No
Coordination problems - difficulties buttoning clothes or change in handwriting? □ Yes □ No

Circle all health conditions for which you have been diagnosed:

Heart disease	History of blood clots	hypertension	blood disorder	GI disorder
Lung disease	asthma	tuberculosis	liver disease	hepatitis
Epilepsy	chemical dependency	diabetes	fibromyalgia	HIV
Osteoporosis	hypocholesterolemia	hypothyroidism	kidney disease	alcoholism

Cancer (type:_____) Other: _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

SPINE QUESTIONNAIRE, PAGE THREE

Please describe and list the approximate date of any surgery you have had: _____

_____

_____

Please list ALL medications you currently take, the dosage and reason for taking each:

Medication	Dosage (Amount and frequency)	Reason

FAMILY HISTORY

	Alive (age and illness)	Deceased (age and illness)
Mother		
Father		
Siblings		
Spouse		
Children		

Smoking: □ current smoker □ former smoker □ never smoked

How much do you smoke most days? _____

How much alcohol do you drink in an average week? _____

Have you ever taken illicit drugs? □ Yes □ No **What?** _____

Have you retained an attorney because of your spine problem? _____

Occupation: _____ **Average # of hours worked/week:** _____

Work status: _____

Name and address of employer: _____

What are the physical requirements of your work? _____

_____

INSURANCE INFORMATION:

Company Name: _____

Subscriber name: _____ **Subscriber Date of Birth** _____

Policy #: _____

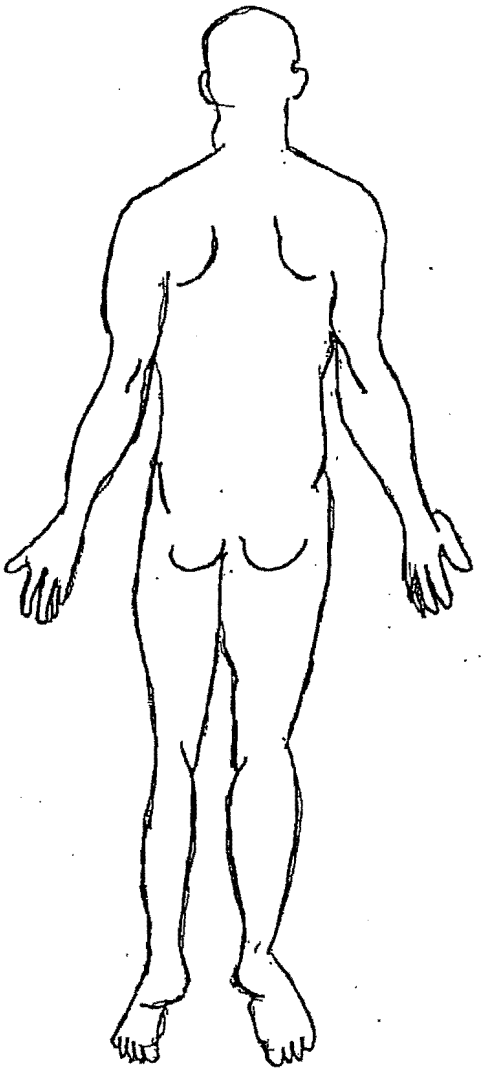
WORKERS COMPENSATION? ____ **Contact:** _____

EMERGENCY CONTACT NAME & PHONE: _____

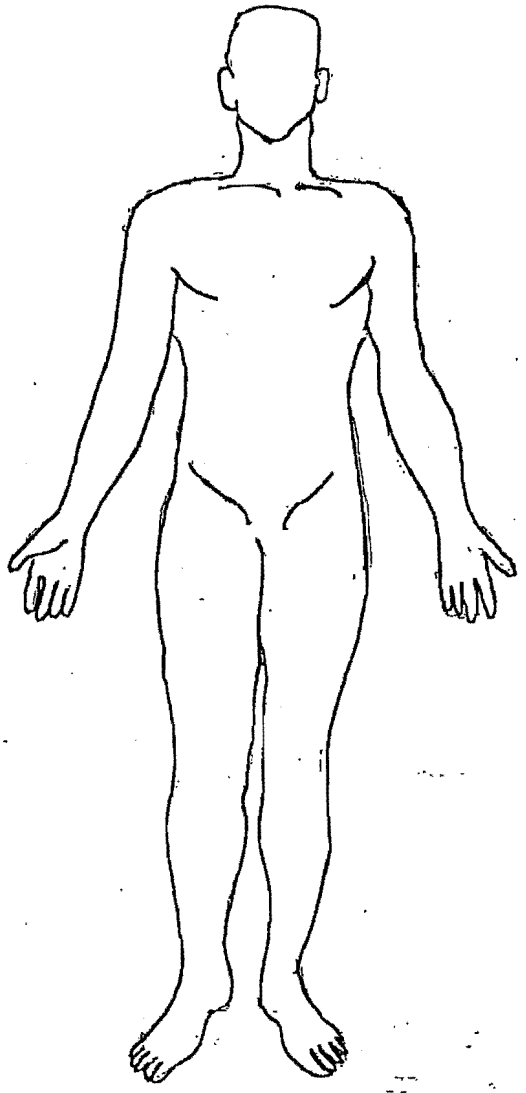
Mark the areas of your body where you feel the described sensation. Use the appropriate symbol. Mark all areas including any areas of radiation.

Pain xxxx
Numbness 0000
Tingling ////

BACK



FRONT



_____ On a scale of 1-10, if surgery could get rid of all symptoms, how likely would you be to have surgery?

Oswestry Disability Questionnaire

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 nfor the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just check the spot that indicates the statement which most clearly describes you problem.

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 faily 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 (e.g. washing, dressing)
- □ I can look after myself normally without Causing extra pain
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful
- □ I need some help but can 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 gives me extra pain
- □ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed, eg. on a table
- □ Pain prevents me lifting heavy weights but I can manage Light to medium weights if they are conveniently positioned
- □ I can only lift very light weights
- □ I cannot lift or carry anything

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 ½ mile
- □ Pain prevents me from walking ¼ mile
- □ I can only walk using a stick or crutches
- □ I am in bed most of the time

Section 5: 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 more than one hour
- □ Pain prevents me from sitting more than 30 minutes
- □ Pain prevents me from sitting 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 can stand as long as I want but it gives me extra pain
- □ Pain prevents me from standing for more than one hour
- □ Pain prevents me from standing more than 30 minutes
- □ Pain prevents me from standing 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 (If applicable)
- □ 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 gives 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
- □ 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 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 over 2 hours
- □ Pain restricts me to journeys of less than 1 Hour
- □ Pain restricts me to short necessary journeys under 30 minutes
- □ Pain prevents me from traveling except to receive treatment

PATIENT NAME _____ DATE _____

Modified Oswestry – Neck Disability Index

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

Section 1 – Pain intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ 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 (washing, dressing, etc.)
- ☐ 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they 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 to 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 can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of moderate pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which 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 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't 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 can't drive my car at all.

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

Section 10 – Recreation
- ☐ I am able to engage in all of my recreation activities with no pain in my neck.
- ☐ I am able to engage in all of my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreation activities because of pain in my neck.
- ☐ I am able to engage in only a few of my recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all.

Patient Name _____ **Date** _____