PATIENT INFORMATION

Patient's surname _____ Title _____

Patient's full names _____

Date of birth _____ Age _____

Marital status _____ Occupation _____

ID number _____ Home tel _____

Cell nr (Patient) _____ Work tel _____

Cell nr (Spouse) _____ Email _____

Employer _____

Medical aid _____ Dependent nr _____

Option _____ Medical aid nr _____

Full name and surname of main member _____

ID number of main member _____

Home address _____

_____

Existing patient ☐ **New patient ☐**

OTHER

Referred by _____

Tel _____ Fax/Email _____

General Practitioner _____

Tel _____ Fax/Email _____

Name, address and tel nr of family/friend _____

_____

I, _____ (full name and surname)

note that this practice does not handle **ANY** *on-duty injuries, road accident fund claims or medico-legal claims/reports.*

Signature _____ **Date** _____

PLEASE ANSWER **ALL** THE QUESTIONS, BE AS ACCURATE AS POSSIBLE
*Please **sign** and **date** each page*

Date dd/mm/yyyy What is the problem? Back ☐ Neck ☐

Name _____ How long have you had this problem? _____

Male ☐ Female ☐ Age _____ 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 a Specialist When _____ Yes ☐ No ☐ Who? _____

Seen a Physiotherapist ☐ Chiropractor ☐ Biokineticist ☐ DBC ☐ Who? _____

When _____ How many sessions _____

MRI / CT scan Yes ☐ No ☐ Where? _____

When _____

Signature _____ **Date** _____

Have you ever had surgery / pain procedures on your 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. _____
6. _____

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 / Xarelto or any other? Yes ☐ No ☐

Are you **ALLERGIC** to any medication / food / material? Yes ☐ No ☐
Please list: _____

Do you suffer from **SLEEP APNOEA** Yes ☐ No ☐ Unsure ☐ and/or use **CPAP** Yes ☐ No ☐

Signature _____ **Date** _____

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 _____
4. _____ Year _____ Surgeon _____
5. _____ Year _____ Surgeon _____

Social History

Marital status Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed ☐

Smoking ☐ Vaping ☐ Yes ☐ No ☐ Previously ☐ **Amount** _____ per day
Date started _____ Stopped _____

Alcohol Yes ☐ No ☐ Previously ☐ **Amount** _____ drinks per day

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

Occupation _____

Medical Aid Fund Name _____ Plan _____

Please note: Appointments must be cancelled ***at least 48 hours*** before the consultation.

If not cancelled 48 hours prior, an account for the full consultation fee will be issued.

Consultation rooms are located at (unless otherwise specified):

The Club Surgical Centre

1st Floor

30 Pinaster Avenue

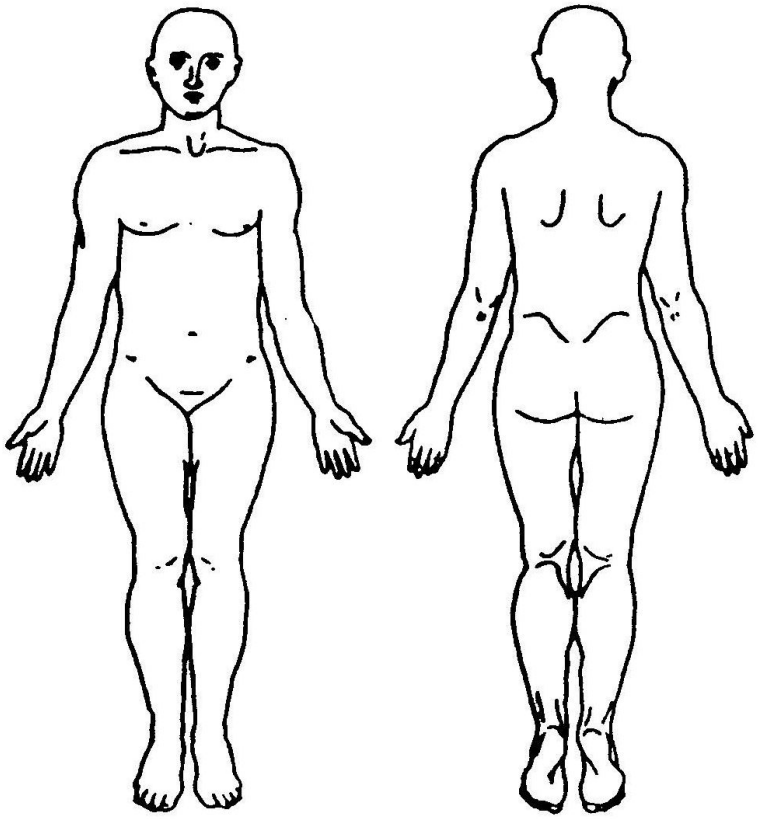
Hazelwood, Pretoria

012-343 4400

Signature _____ **Date** _____

INDICATE ON THE SKETCH <u>WHERE</u> 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 = No pain at all **10** = Worst possible pain

Neck pain	0 1 2 3 4 5 6 7 8 9 10
Left arm pain	0 1 2 3 4 5 6 7 8 9 10
Right arm pain	0 1 2 3 4 5 6 7 8 9 10
Thoracic pain	0 1 2 3 4 5 6 7 8 9 10
Lower back pain	0 1 2 3 4 5 6 7 8 9 10
Left leg pain	0 1 2 3 4 5 6 7 8 9 10
Right leg pain	0 1 2 3 4 5 6 7 8 9 10

Signature _____ **Date** _____

OSWESTRY DISABILITY INDEX 2.1A
COMPLETE THIS PAGE IF YOU HAVE A *BACK PROBLEM*
Tick only **one** appropriate answer per statement, ***please do not write comments***

Section 1 – Pain intensity
O I have no pain at the moment
O The pain is very mild at the moment
O The pain is moderate at the moment
O The pain is fairly severe at the moment
O The pain is very severe at the moment
O The pain is the worse imaginable at the moment

Section 2 – Personal care (washing, dressing, etc.)
O I can look after myself normally without causing extra pain
O I can look after myself normally but it is very painful
O It is painful to look after myself and I am slow and careful
O I need some help but manage most of my personal care
O I need help every day in most aspects of self care
O I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting
O I can lift heavy weights without extra pain
O I can lift heavy weights but it gives extra pain
O Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
O Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
O I can lift only very light weights
O I cannot lift or carry anything at all

Section 4 – Walking
O Pain does not prevent me walking any distance
O Pain prevents me walking more than 2 kilometers
O Pain prevents me walking more than 1 kilometer
O Pain prevents me walking more than 500 meters
O I can only walk using a stick or crutch
O I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting
O I can sit in any chair for as long as I like
O I can sit in my favourite chair for as long as I like
O Pain prevents me from sitting for more than 1 hour
O Pain prevents me from sitting for more than half an hour
O Pain prevents me from sitting for more than 10 minutes
O Pain prevents me from sitting at all

Section 6 – Standing
O I can stand as long as I want without extra pain
O I can stand as I want but it gives me extra pain
O Pain prevents me from standing for more than 1 hour
O Pain prevents me from standing for more than half an hour
O Pain prevents me from standing for more than 10 minutes
O Pain prevents me from standing at all

Section 7 – Sleeping
O My sleep is never disturbed by pain
O My sleep is occasionally disturbed by pain
O Because of pain I have less than 6 hours of sleep
O Because of pain I have less than 4 hours of sleep
O Because of pain I have less than 2 hours of sleep
O Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)
O My sex life is normal and causes no extra pain
O My sex life is normal but causes some extra pain
O My sex life is nearly normal but is very painful
O My sex life is severely restricted by pain
O My sex life is nearly absent because of pain
O Pain prevents any sex life at all

Section 9 – Social life
O My social life is normal and causes me no extra pain
O My social life is normal but increases the degree of pain
O Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
O Pain has restricted my social life and I do not go out as often
O Pain has restricted social life to my home
O I have no social life because of pain

Section 10 – Travelling
O I can travel anywhere without pain
O I can travel anywhere but it gives extra pain
O Pain is bad but I manage journeys over 2 hours
O Pain restricts me to journeys of less than one hour
O Pain restricts me to short necessary journeys under 30 minutes
O Pain prevents me from travelling except to receive treatment

Signature _____ **Date** _____

COMPLETE THIS PAGE IF YOU HAVE A *NECK PROBLEM*

Tick only **one** appropriate answer per statement, ***please do not write comments***

Section 1 – Pain Intensity
- **O** I have no pain at the moment
- **O** The pain is very mild at the moment
- **O** The pain is moderate at the moment
- **O** The pain is fairly severe at the moment
- **O** The pain is very severe at the moment
- **O** The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc)
- **O** I can look after myself normally without causing extra pain
- **O** I can look after myself normally but it causes extra pain
- **O** It is painful to look after myself and I am slow and careful
- **O** I need some help but manage most of my personal care
- **O** I need help every day in most aspects of self care
- **O** I do not get dressed, I wash with difficulty and stay in bed

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

Section 4 – Reading
- **O** I can read as much as I want to with no pain in my neck
- **O** I can read as much as I want to with slight pain in my neck
- **O** I can read as much as I want with moderate pain in my neck
- **O** I cannot read as much as I want because of moderate pain in my neck
- **O** I can hardly read at all because of severe pain in my neck
- **O** I cannot read at all

Section 5 – Headaches
- **O** I have no headaches at all
- **O** I have slight headaches that come infrequently
- **O** I have moderate headaches which come infrequently
- **O** I have moderate headaches which come frequently
- **O** I have severe headaches which come frequently
- **O** I have headaches almost all the time

Section 6 – Concentration
- **O** I can concentrate fully when I want to with no difficulty
- **O** I can concentrate fully when I want to with slight difficulty
- **O** I have a fair degree of difficulty in concentrating when I want to
- **O** I have a lot of difficulty in concentrating when I want to
- **O** I have a great deal of difficulty in concentrating when I want to
- **O** I cannot concentrate at all

Section 7 – Work
- **O** I can do as much work as I want to
- **O** I can do my usual work, but no more
- **O** I can do most of my usual work, but no more
- **O** I cannot do my usual work
- **O** I can hardly do any work at all
- **O** I cannot do any work at all

Section 8 – Driving
- **O** I can drive my car without any neck pain
- **O** I can drive my car as long as I want with slight pain in my neck
- **O** I can drive my car as long as I want with moderate pain in my neck
- **O** I cannot drive my car as long as I want because of moderate pain in my neck
- **O** I can hardly drive at all because of severe pain in my neck
- **O** I cannot drive my car at all

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

Section 10 – Recreation
- **O** I am able to engage in all my recreation activities with no neck pain at all
- **O** I am able to engage in all my recreation activities, with some pain in my neck
- **O** I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- **O** I am able to engage in a few of my usual recreation activities because of pain in my neck
- **O** I can hardly do any recreation activities because of pain in my neck
- **O** I cannot do any recreation activities at all

Signature _____ **Date** _____

PROMIS–29 Profile v2.1

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP04	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP08	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI7	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AN3	I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Signature _____ **Date** _____

Fatigue

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP41	How run-down did you feel on average? ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FATEXP40	How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
Sleep109	My sleep quality was.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep118	My sleep was refreshing.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Ability to Participate in Social Roles and Activities

		Never	Rarely	Sometimes	Usually	Always
SRPPER11_CaPS	I have trouble doing all of my regular leisure activities with others.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER18_CaPS	I have trouble doing all of the family activities that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER23_CaPS	I have trouble doing all of my usual work (include work at home)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER48_CaPS	I have trouble doing all of the activities with friends that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9	How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31	How much did pain interfere with your ability to participate in social activities? .	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Intensity

	In the past 7 days…											
Global07	How would you rate your pain on average?.....	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst pain imaginable

Signature _____ **Date** _____

Please email the completed document to info@spineafrica.co.za

Please ensure you have completed **all** the sections and that all the pages are signed.

Spine Africa consultation rooms are located at The Club Surgical Centre, 1st Floor, 30 Pinaster Street, Hazelwood, Pretoria (unless otherwise specified).

Underground parking is available in the building via the 18th Street entrance.

Patient Image Sharing Consent

The following consent allows us to obtain images of your X-Rays and scans from the radiology practice.

I _____ ID nr _____

hereby give permission to The Radiologist to send electronic medical information to the following email address:

info@spineafrica.co.za

Signed……

Date……

For Office use only:
Accession Number:……

Signature _____ **Date** _____