Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please shade out the spot that indicates the statement **which most clearly describes your 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 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 (eg. 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, e.g. 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 walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ 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 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ 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 of sleep
- ☐ Because of pain I have less than 4 hours of sleep
- ☐ Because of pain I have less than 2 hours of 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 two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys of under 30 minutes
- ☐ Pain prevents me from traveling except to receive treatment

The Corrado-Gottlieb TOPS

Name: _____ Date: _____

Age: _____ Gender: _____

Please mark one response for each of the following questions or statements:

1. What is your highest level of education?

☐ Did not complete high school ☐ Completed high school/GED ☐ Some college ☐ College degree or higher

1. What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living with Partner

1. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), what is the lowest your pain has been during the past six months?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1. On a scale from 0 to 10 (with O being an absence of pain and 10 being the most intense pain), rate your average pain level over last six months.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

1. I feel like giving up because things will not get better for me.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I believe that I will be happier in the future than I am now.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I believe I will be able to return to work and/or successfully perform the activities of daily living.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I lack interest or pleasure in the things I used to enjoy.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I feel tired, fatigued, run down, and/or lethargic.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I have trouble thinking and concentrating.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

1. I feel incapable of managing my pain.

☐ Always ☐ Often ☐ Sometimes ☐ Rarely/Never

EVALUATION FOR CURRENT TREATMENT

PAIN RELIEF SOLUTIONS

Name: _____ **Phone Number:** _____

Date of Birth: _____ **Date:** _____ **Height:** _____ **Weight:** _____

PAIN ASSESSMENT

On a scale from 0 to 10, please rank your pain today:

0 (No pain) 1 2 3 4 5 6 (Moderate pain) 7 8 9 10 (Worst possible pain)

Where does it hurt the worst? _____ **Where else does it hurt?** _____

Does the pain radiate? Yes / No **Where?** _____

Is this a new problem? Yes / No **How long have you had this problem? (circle one)** 1-3 4-7 > 8 days/months/years

Describe your pain: (circle all) Sharp Stabbing Dull Aching Burning Electrical Throbbing Shooting

What is the severity? Mild / Moderate / Severe **Is the pain (circle one):** constant or intermittent

What makes your pain worse? (circle all) Walking Sitting Bending Extension Twisting Working Exercise Cold

What makes your pain better? (circle all) Heat Ice Laying Down Rest Stretching Medication Procedures/Injections

Associated Symptoms: (circle all) Numbness Tingling Weakness Incontinence Depression Fatigue Anxiety

If pain has been constant and lasted >than 6 months, please answer below:

My level of frustration with my pain?

Not Frustrated - 0 1 2 3 4 5 6 7 8 9 10 - **Very Frustrated**

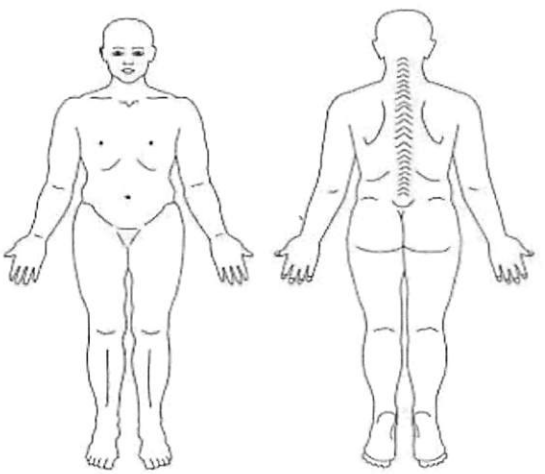
YES or NO: I still have pain when I sit or lay in bed

YES or NO: I have tried medications to manage my pain

YES or NO: My pain rating is equal or greater than 5

YES or NO: If "YES" to above questions, you may be a candidate for a treatment option our practice offers, would you like to learn more?

Mark on the diagram below where your pain is located:



MEDICATIONS/ THERAPIES/ IMAGING

What is your preferred pharmacy? _____

Pain relief from current medication regimen? _____ %

Any side effects? Yes / No **Do you need refills?** Yes / No

Recent procedure? Yes / No **Pain relief?** _____ %

Recent imaging? Yes / No **Facility?** _____

Other treatments? (circle all) Physical Therapy Home Exercise

Diabetes? Yes / No **Smoker** Yes / No **Allergies?** Yes / No _____

********** *for office use only* **********

Description	Description Blood Pressure_____/_____ Pulse_____ EPCS? YES or NO
Med Management	UDS ODS Med Management ORT BIOMARKER
Insurance	PPO HMO MPMG SRS SCMG CCIPA VMG CHG Molina Care1st Medicare Medical VA Tricare WC

_____

_____

PAIN RELIEF
SOLUTIONS

HIPPA Compliance Requirement Form
Notice of Pain Relief Solutions Privacy Practices

THIS DOCUMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO SUCH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to ask each of our patients to acknowledge receipt of our Notice of Privacy Practices. Pain Relief Solutions must take steps to protect the privacy of your Protected Health Information ("PHI") in accordance with HIPAA. PHI includes information that we have created or received regarding your health care, including payment and billing for your health care. In addition to your medical records, PHI includes personal information such as your name, social security number, address and phone number.

Under federal law, we are required to: (i) protect the privacy of your PHI (Pain Relief Solutions therefor requires our employees to maintain the confidentiality of PHI); (ii) provide you with this Notice of Pain Relief Solution's Privacy Practices explaining our duties and practices regarding your PHI; and (iii) follow the practices and procedures set forth in this Notice of Pain Relief Solution's Privacy Practices.

I, _____, understand that as a part of my healthcare, Pain Relief Solutions originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as follows:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment to my bill
- A means by which a third-party payer can verify services billed were provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

Email: You are advised that email is not a secure method of communication. If you email us you agree to our communication by use of email and you agree to the risks.

Telephone: You are advised that telephonic communication is not a secure form of communication. You understand and agree that such communication may include calls, voicemails and/or test messages.

My PHI may be discussed with the following people:

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

I hereby agree to the above and consent for Pain Relief Solutions to obtain my past, present and future medication and medical information as well as all other PHI.

_____ _____

Patient's Signature Date

A more detailed list of our Privacy Practices is available upon request

REVISED 11/24/2020

PAIN RELIEF
SOLUTIONS

Cancellation Policy

We kindly request that you give our office at least 24 hours advance notice if you need to reschedule or cancel your appointment.

- To cancel/ reschedule your appointment, call us directly. If you reach our voicemail, please leave a message with your name, date of birth, and date and time of your appointment.
- In the event you fail to give at least 24 hours advance notice to reschedule or cancel your appointment, you may be charged a $25 fee for any office visit, $50 fee for an in-office procedure or $150 for a Spinal Cord Stimulator Trial. This fee will not be billed to the insurance company.
- If you are over ten (10) minutes late to your appointment, it may result in a cancelled appointment and, as determined by Pain Relief Solutions, you may be responsible for the cancellation fee.

I have read and understand the Patient Cancellation Responsibility Policy. I also understand that Pain Relief Solutions may amend such terms at any time.

_____	_____
Printed Name of Patient	Your Name and Relationship to Patient
_____	_____
Patient's Signature	Date

PAIN RELIEF
SOLUTIONS

Patient Financial Responsibility Policy

Co-Payments are due when services are rendered

- If the patient is unable to pay the copayment at the time of the appointment, said appointment will be rescheduled.
- Any deductible, copayment, or balance not paid by a patient's insurance is the patient's financial responsibility. Insured patients are responsible for all charges not paid by their insurance within 45 days after the date of service.
- There is a $25 service fee on all returned checks.
- Always bring your insurance card and ID to your appointment. If your coverage cannot be verified, you will be responsible for any payments at the time of service.

If you have:	You are responsible for:	Our staff will:
PPO/HMO	Payment of copay, deductible and non-covered services for office visits, procedures and other charges.	Check your insurance coverage to determine co-pays. File your insurance claim
Worker's Compensation	If we have verified the claim with your carrier, no payment is necessary at the time of visit. If we are not able to verify your claim, the appointment will be rescheduled until authorization is obtained.	Verify your claim and obtain authorization. File your claim.

- It is your responsibility to notify us if there are any changes to your insurance, address or phone number.
- Pain Relief Solutions will bill the insurance on your behalf.
- Payment of insurance benefits will be paid directly to Pain Relief Solutions.

I have read and understand the Patient Financial Responsibility Policy and I agree to all of the terms and conditions contained herein.

_____ _____

Patient's Signature Date

REVISED 11/24/2020

PAIN RELIEF
SOLUTIONS

Welcome to Pain Relief Solutions.

Your care and comfort are most important to us. In order to better serve our patients, please review and complete this packet, in its entirety, prior to your consultation.

Your first appointment will be a consultation, please bring the following items:

- Picture ID Card
- Insurance Card
- A list of all medications the patient is taking
- This packet completed in its entirety

Disclosure of insurance and other information is necessary

- If the patient's injury is due to any type of personal injury, accident or malicious conduct for which the patient is seeking damages, the patient must notify us and sign a lien in our favor.
- Your failure to make necessary disclosures will result in patient's responsibility for all charges incurred for services rendered by us.

Abusive Patient Policy

- For the safety of our patients and staff, Pain Relief Solutions has a ZERO TOLERANCE POLICY for any threatening or abusive behavior, verbal or physical, against anyone in this facility. Such behavior may result in the immediate termination of the Provider-Patient relationship.

I hereby consent to the patient's evaluation and treatment by Pain Relief Solutions ("PRS") and their health care providers.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Representative's Name: _____ Date: _____

Representative's Signature_____ Rel. to Pt.: _____