



Castle Orthopaedics & Sports Medicine, S.C.

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Board Certified Orthopaedic Surgeons

Today's Date _____

SPINE SHEET

This information is necessary for evaluation of your spinal problem. Please fill in prior to being seen by Dr. McGivney.

Name _____ Age _____ Sex _____ Height _____ Weight _____

Referred by _____ Reason for evaluation _____

Present Occupation (work) _____ How long? _____

Previous job _____ How long? _____

Chief complaint (problem) _____

Date of first episode of pain _____

Injury or accident: Yes _____ No _____

Date of injury _____

The area of body injured _____

Any back or neck trouble prior to injury? Yes _____ No _____

State in your own words how the accident or injury happened and what you felt at the time (symptoms). In the accident, how and when did the pain start?

When did most recent episode start? _____

Which pain is worse? Back _____ Leg _____ Arm _____ Shoulder _____

Pain at night? Yes _____ No _____

Pain at rest? Yes _____ No _____

Pain increase with coughing or sneezing? Yes _____ No _____

Do you smoke cigarettes? Yes _____ No _____ How much? _____

Past or current major medical illnesses:

Diabetes? Yes _____ No _____ Allergies? Yes _____ No _____

Specify _____

Weight loss? Yes _____ No _____ How many pounds? _____

Previous Operations or Hospitalizations:

Operation	Hospitalization	Date
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Mark the area or region on the diagram where you have any of the following sensations:

Ache
^ ^ ^

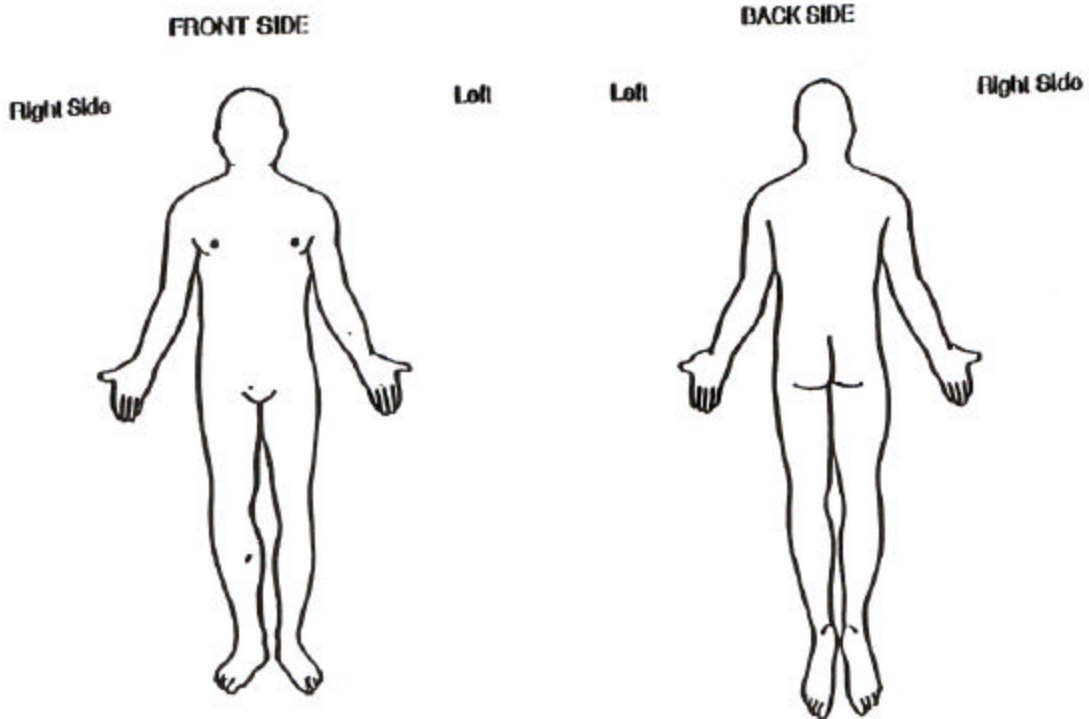
Numbness
ooo

Pins & Needles
x x x x

Stabbing
///

Burning
#

Shooting
???



How bad is the pain on a 0-10 scale?

0 1 2 3 4 5 6 7 8 9 10
MILD WORST

Does anything make your pain better? _____

Does anything make your pain worse? _____

How often do you have pain?

All of the time _____ Everyday _____

Most of the time _____ Once a week _____

Some of the time _____ Once a month _____

Is the pain better, same or worse than 1 month ago? _____

Have you had: Yes No

Bowel control damages _____

Bladder control changes _____

Weakness of legs or feet _____

Numbness of legs or feet _____

Previous doctors for spine problem: _____

Have you had: Yes No Has it helped: Yes No

Bed Rest _____

Traction _____

P.T. Exercise _____

Chiropractic manipulation _____

Spine injection _____

Anti-inflammatory medicines _____

Pain medicines _____

Current medication: _____

Prescribed by: _____

Have you had: Yes No Where? When?

Spine X-Rays _____

CT Scan _____

MRI _____

Bone Scan _____

EMG _____

Myelogram _____

Recent blood tests _____

Do you have recent x-rays with you today? Yes_____ No_____ YOU must bring all recent x-rays.

Are you currently working? Yes_____ No_____

Date last worked at your employment _____

How long have you been unable to work or do normal housework? _____

Physical Impairment Estimate

If you are currently not able to do your normal working activities due to an injury or illness and require documentation for Workmen's Comp or insurance purposes, please fill in the following estimates to help your doctor document any physical impairment.

Do you feel you are disabled from your regular work?

No Yes

Do you feel you are disabled from doing any work?

No Yes

In an 8 hour workday I can:

Stand:	None	1-4 hrs.	4-8 hrs.	
Walk:	None	1-4 hrs.	4-8 hrs.	
Sit:	None	1-4 hrs.	4-8 hrs.	
Drive:	None	1-4 hrs.	4-8 hrs.	
Bend:	None	1-4 hrs.	4-8 hrs.	
Squat:	None	1-4 hrs.	4-8 hrs.	
Climb:	None	1-4 hrs.	4-8 hrs.	
Grasping:	None	1-4 hrs.	4-8 hrs.	
Fine manip.:	None	1-4 hrs.	4-8 hrs.	
Pushing & pulling	None	1-4 hrs.	4-8 hrs.	
Lift frequently:	10 lbs.	20 lbs.	40 lbs.	50 lbs. +
Lifting occasionally:	10 lbs.	20 lbs.	40 lbs.	50 lbs. +

I feel I am able to do:

Very Heavy Work – no restrictions
lifting over 100 lbs. – carrying over 50 lbs.
Heavy Work – Class 1
lifting up to 100lbs. – carrying up to 50 lbs.

I feel I am restricted to:

Medium work – 20% reduced capacity – Class 2
lifting up to 50 lbs. – carrying up to 25 lbs.
Light Work – 40% reduced capacity – Class 3
lifting up to 20 lbs. – carrying up to 10 lbs.
Sedentary Work – 60% reduced capacity – Class 4
lifting up to 10 lbs. – carrying up to 5 lbs.
Incapable of Minimal Activity – 80-100% reduced capacity – Class 5

The reason for my limitation is:

Pain _____

Paralysis _____

Deformity _____

Other _____