Neel Anand, MD, Mch, Orth
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Notice and Patient Agreement Regarding Out-Of-Network Fees

Out-Of-Network Provider - General

This Agreement confirms what we have already advised you that Neel Anand, M.D., is not a participating provider in the provider network available through your health insurance plan. Dr. Anand's out-of-network status applies to both inpatient and outpatient services provided at Cedars-Sinai facilities.

While Neel Anand, M.D. is not an in-network with your insurance company, we are still able to bill your health insurer. It is your responsibility to verify what your health insurance benefits are. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s). Please let us know if you have more than one insurance carrier and which carrier is primary and which is secondary.

Today we may be providing you with an additional form to allow our billing office to contact your insurance company directly for payment. If so, please sign that form before services are rendered.

Cost Estimates for Outpatient Services

This Agreement has been prepared in anticipation of an upcoming visit or consultation you may have with Dr. Neel Anand on ____________________________, 2017. We will bill your insurance and collect from them whatever they pay. If the check is issued to you from your insurance company for services rendered by Dr. Anand and his team, it is your duty to endorse the check over to Neel Anand, MD, Inc.

Maximum Out of Pocket: The maximum out-of-pocket for this outpatient visit will be: $300.00. This fee will be collected at the time of your visit.

Future office visits with Dr. Neel Anand will also be considered out of network and maximum out-of-pocket will be $200.00 per visit. This fee will be collected at the time of your visit.

Cost Estimates for Inpatient Consultations

You may agree with Dr. Neel Anand or your primary care physician to receive inpatient consultation from Dr. Neel Anand at some future date, including during an inpatient hospital stay.

Dr. Neel Anand's estimated out of pocket costs that would be billed to you for such services are as follows: up to a maximum of $300.00.

If you need an elective surgery or procedure by Dr. Neel Anand, an additional financial consent with estimated out of pocket maximums will be provided.

Additional Amounts – Unexpected Amounts

Dr. Neel Anand will not expect to collect from you more than the amounts estimated or described in this Agreement without your written consent unless circumstances arise during the delivery of services that were unforeseeable at the time the estimate was provided that would require Dr. Neel Anand to revise the estimate.

__Specific Agreement Regarding Services Covered By California's Surprise Medical Bill Law (Calif. AB 72)__

The State of California has recently passed legislation designed to provide patients financial protection when they receive services from an out-of-network provider while they are an inpatient or outpatient of a contracted facility. Unless the patient and the provider agree at least 24 hours in advance that the patient will be billed an identified amount, the patient's health insurer will be entitled to calculate a payment to be made to the provider (and the patient's co-insurance would be based on this amount).

Dr. Neel Anand has elected not to provide non-emergency services to patients under this payment protocol. The California legislation permits patients and providers to opt out of the legislated payment rate.

By signing below, you agree that your payment agreement with Dr. Neel Anand will be in accordance with the financial terms outlined in this Agreement and that payment will not be made to Dr. Neel Anand by your health insurer in the default manner provided by the recent California legislation. You understand that this will likely be at a higher cost to you than if you utilized your in-network benefits. **The estimate of your anticipated total out-of-pocket cost of care described above is based on Dr. Anand's billed charges. These costs are in addition to any in-network cost sharing that your health insurer may determine is your obligation. You understand that depending on the terms of your health insurance, payments to Dr. Neel Anand might not be included in your annual out-of-pocket maximum for in-network benefits or a deductible, if any, for in-network benefits. In sum, you understand that the benefits you receive from your health insurance plan for the services provided by Dr. Anand will be out-of-network benefits, which are different than in-network benefits.**

__Cedars-Sinai Medical Center__

Please note that while Neel Anand, M.D. is an out-of-network provider it is likely that Cedars-Sinai Medical Center is in your network. Our office staff can find you assistance to address any questions you may have regarding Medical Center insurance coverage.

__**Referrals**__

If after reading the forgoing you wish to obtain services from an in-network provider we will do what we can to assist you in obtaining a referral, which may consist of asking your primary care physician to provide you with other options.

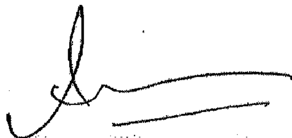
__**Agreement**__

I understand and agree to the statements contained in this Agreement and have had my questions answered to my satisfaction.

This Agreement will remain in effect until I provide Dr. Neel Anand a written notice of termination.

Patient Name: ______________________________ Date: ______________________

Signature: ________________________________ Time: ______________________



Neel Anand, MD

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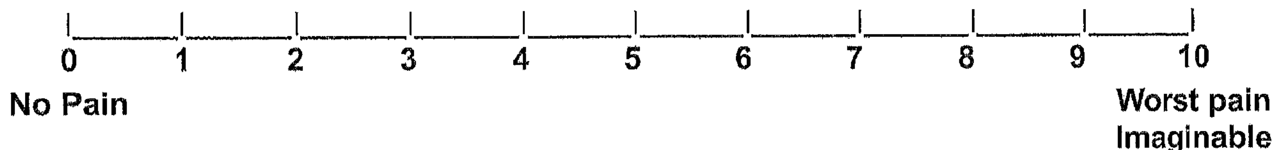
CEDARS-SINAI MEDICAL CENTER.
SPINE CENTER

PAIN DRAWING

PATIENT I.D.

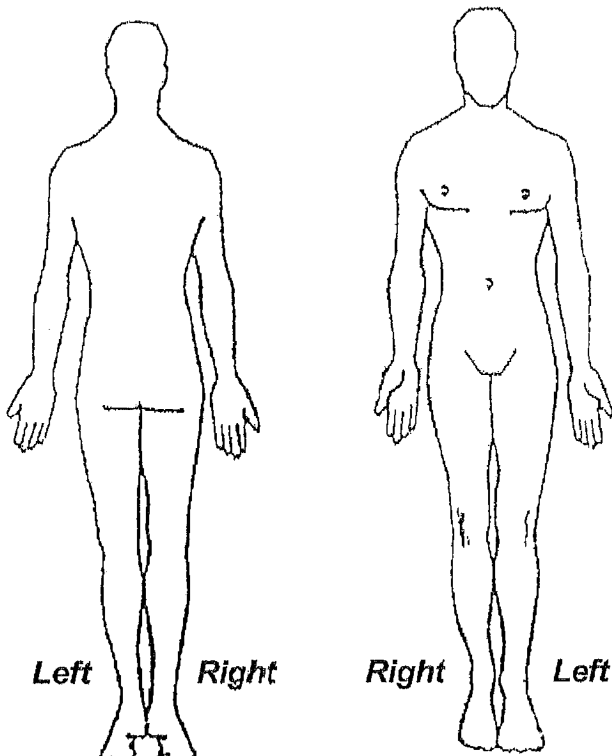
1. **How much pain in general can you tolerate?**

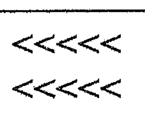
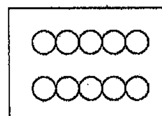
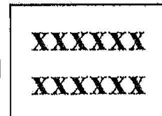
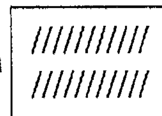


No Pain — Worst pain Imaginable

2. **Where is your pain now?**

Mark the areas on your body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN	SYMBOL
Ache	
Numbness	
Pins & Needles	
Burning	
Radiating Pain	

3. **How bad is your pain?**

Neck pain ______ %

Arm pain ______ %

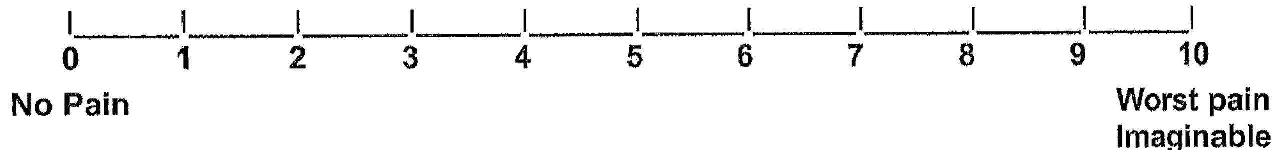
Total 100%

Back pain ______ %

Leg pain ______ %

Total 100%

4. **How bad is your pain now?**



No Pain — Worst pain Imaginable

5. **The duration of pain:**

❑ Continuous ❑ Positional ❑ Intermittent (On/Off) ❑ Unable to Rate

6. **Have you taken pain medication in the past 24 hours?**

❑ YES ❑ NO

Pt/Study ID:_______________ Visit Date:_______________

CLINICAL EXAMINATION (PATIENT)

Patient Name:	DOB:	Gender:	Race:

Patient History

Bowel incontinence Yes ☐ No ☐ | Numbness/tingling in legs Yes ☐ No ☐ | Leg weakness Yes ☐ No ☐

Bladder incontinence Yes ☐ No ☐ | Loss of balance Yes ☐ No ☐

Method of treatment to date? *(Check all that apply)*	Rate of relief associated with treatment?	Duration of relief (0-3mos, 3-6mos, 6-12mos, >1yr)
None☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Bracing☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Chiropractor☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Injection – spine☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
NSAIDS☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Narcotics☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Pain program☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Physical therapy☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐
Other☐	0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐

Past Medical History *(check all that apply)*

None☐ / Alcohol/drug abuse☐ / Anemia☐ / Arthritis☐ / Blood clots☐ / Cancer☐ / Depression☐ / Diabetes☐ / Heart disease ☐ / Hypertension☐ / Kidney disease☐ / Liver disease☐ / Lung disease☐ / Nervous system disorders☐ / Osteoporosis☐ / Peripheral vascular disease☐ / Psychiatric disorders☐ / Ulcers and/or stomach disease☐ / Other☐ please list:_______________

Work status *(check one)*
Employed☐ /Disabled ☐ /Retired due to back pain ☐ /Retired☐ / Unemployed ☐

Level of physical labor in your job *(check one)*
Heavy☐ /Moderate☐ /Minimal☐ /No physical labor ☐

Do you smoke?
Yes ☐ / No ☐

If yes, how much do you smoke? *(check one)*
Less than 1pk/day☐ /1pk/day☐ / 2pk/day☐ /3pk or more/day☐

If quit, how long? *(check one)*
0-6 months☐ /6-12 months☐ / 1yr or greater ☐ / 2yrs or greater☐

PI/Study ID:______________ Visit Date:______________

PAIN ASSESSMENT TOOL (PATIENT)

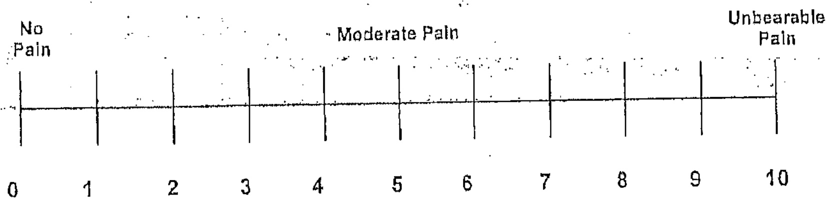
Please take a moment to review the scales shown below and mark appropriately.
Note: The top scale relates to leg pain and the bottom scale relates to back pain.

Please check one:

- ☐ Back pain: 0% Leg pain: 100%
- ☐ Back pain: 10% Leg pain: 90%
- ☐ Back pain: 25% Leg pain: 75%
- ☐ Back pain: 50% Leg pain: 50%
- ☐ Back pain: 75% Leg pain: 25%
- ☐ Back pain: 90% Leg pain: 10%
- ☐ Back pain: 100% Leg pain: 0%

Numeric Rating Scale (NRS)
Leg Pain

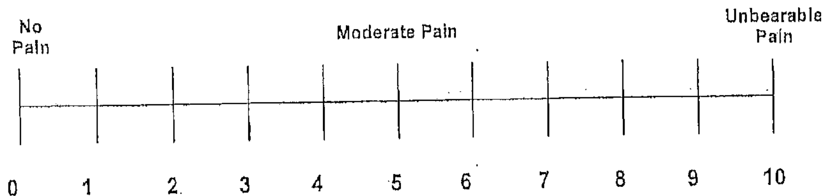
Please mark an "X" on the line below that best describes the level of pain you have experienced in the past month.



If pain, how long has Leg Pain been present?
1yr☐ / 5yrs☐ / 10yrs☐ / 15yrs☐ / 20yrs or greater☐

Numeric Rating Scale (NRS)
Back Pain

Please mark an "X" on the line below that best describes the level of pain you have experienced in the past month.



If pain, how long has Back Pain been present?
1yr☐ / 5yrs☐ / 10yrs☐ / 15yrs☐ / 20yrs or greater☐

Please answer by marking one box in each section for the statement which best applies to you.

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	☐
Personal Care (Washing, Dressing, etc)	
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	☐
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	☐
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	☐

The following section contains two columns of questions. Please complete the left column if your pain is primarily lumbar / lower back pain. Please complete the right column if your pain is primarily cervical / neck pain. Do not complete both columns.

LUMBAR / LOWER BACK PAIN		**CERVICAL / NECK PAIN**	
Walking		**Headache**	
Pain does not prevent me walking any distance	☐	I have no headaches at all	☐
Pain prevents me from walking more than 1 mile	☐	I have slight headaches that come infrequently	☐
Pain prevents me from walking more than 1 half mile	☐	I have moderate headaches that come infrequently	☐
Pain prevents me from walking more than 1 quarter mile	☐	I have moderate headaches that come frequently	☐
I can only walking using a stick or crutches	☐	I have severe headaches that come frequently	☐
I am in bed most of the time	☐	I have headaches almost all the time	☐
Sitting		**Work**	
I can sit in any chair as long as I like	☐	I can do as much work as I want to	☐
I can only sit in my favorite chair as long as I like	☐	I can do my usual work, but no more	☐
Pain prevents me from sitting more than one hour	☐	I can do most of my usual work, but no more	☐
Pain prevents me from sitting more than 30 minutes	☐	I cannot do my usual work	☐
Pain prevents me from sitting more than 10 minutes	☐	I can hardly do any work at all	☐
Pain prevents me from sitting at all	☐	I can't do any work at all	☐

LUMBAR / LOWER BACK PAIN

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	☐

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	☐

Social Life

My social life is normal and gives 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	☐

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 journeys under 30 minutes	☐
Pain prevents me from traveling except to receive treatment	☐

CERVICAL / NECK PAIN

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 of concentrating when I want to	☐
I cannot concentrate at all	☐

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 to, with moderate pain in my neck	☐
I can't read as much as I want to, because of moderate pain in my neck	☐
I can hardly read at all, because of severe pain in my neck	☐
I cannot read at all	☐

Driving

I can drive my car without 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	☐

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 neck pain	☐
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 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	☐

On average, how bad is your LOWER BACK pain?

0 1 2 3 4 5 6 7 8 9 10

No pain — **Worst Pain Imaginable**

On average, how bad is your NECK pain?

0 1 2 3 4 5 6 7 8 9 10

No pain — **Worst Pain Imaginable**

Thank you for completing these questions!

PI/Study ID:_______________ Visit Date:_______________

Your Health and Well-Being

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. *Thank you for completing this survey!*

For each of the following questions, please mark an ☒ in the one box that best describes your answer.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

2. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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PI/Study ID:______________ Visit Date:______________

3. **The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐ 1	☐ 2	☐ 3
b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
c Lifting or carrying groceries	☐ 1	☐ 2	☐ 3
d Climbing several flights of stairs	☐ 1	☐ 2	☐ 3
e Climbing one flight of stairs	☐ 1	☐ 2	☐ 3
f Bending, kneeling, or stooping	☐ 1	☐ 2	☐ 3
g Walking more than a mile	☐ 1	☐ 2	☐ 3
h Walking several hundred yards	☐ 1	☐ 2	☐ 3
i Walking one hundred yards	☐ 1	☐ 2	☐ 3
j Bathing or dressing yourself	☐ 1	☐ 2	☐ 3

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PI/Study ID:_______________ Visit Date:_______________

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐1	☐2	☐3	☐4	☐5
b Accomplished less than you would like	☐1	☐2	☐3	☐4	☐5
c Were limited in the kind of work or other activities	☐1	☐2	☐3	☐4	☐5
d Had difficulty performing the work or other activities (for example, it took extra effort)	☐1	☐2	☐3	☐4	☐5

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Cut down on the amount of time you spent on work or other activities	☐1	☐2	☐3	☐4	☐5
b Accomplished less than you would like	☐1	☐2	☐3	☐4	☐5
c Did work or other activities less carefully than usual	☐1	☐2	☐3	☐4	☐5

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Pt/Study ID:________________ Visit Date:________________

6. During the <u>past 4 weeks</u>, to what extent has your <u>physical health or emotional problems</u> interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. How much <u>bodily</u> pain have you had during the <u>past 4 weeks</u>?

None	Very mild	Mild	Moderate	Severe	Very Severe
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

8. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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Pt/Study ID:______________ Visit Date:______________

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a Did you feel full of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Have you been very nervous?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Have you felt so down in the dumps that nothing could cheer you up?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f Have you felt downhearted and depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g Did you feel worn out?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h Have you been happy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
i Did you feel tired?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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PI/Study ID:______________ Visit Date:______________

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a I seem to get sick a little easier than other people	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b I am as healthy as anybody I know	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c I expect my health to get worse	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d My health is excellent	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

THANK YOU FOR COMPLETING THESE QUESTIONS!

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Pt/Study ID:______________ Visit Date:______________

By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about ☐
- I have some problems in walking about ☐
- I am confined to bed ☐

Self-Care

- I have no problems with self-care ☐
- I have some problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

- I have no problems with performing my usual activities ☐
- I have some problems with performing my usual activities ☐
- I am unable to perform my usual activities ☐

Pain/Discomfort

- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☐

Anxiety/Depression

- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am extremely anxious or depressed ☐

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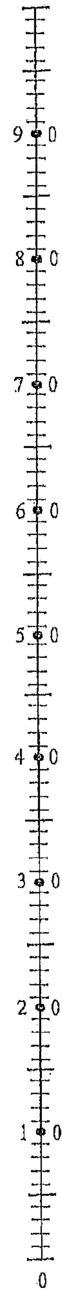
Pt/Study ID:________________ Visit Date:________________

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today

Best imaginable health state



Worst imaginable health state

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Instructions: Please mark the one best answer to each question.

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
□5 None □4 Mild □3 Moderate □2 Moderate to severe □1 Severe

2. Which one of the following best describes the amount of pain you have experienced over the last month?
□5 None □4 Mild □3 Moderate □2 Moderate to severe □1 Severe

3. During the past 6 months have you been a very nervous person?
□5 None of the time □4 A little of the time □3 Some of the time □2 Most of the time □1 All the time

4. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?
□5 Very happy □4 Somewhat happy □3 Neither happy nor unhappy □2 Somewhat unhappy □1 Very unhappy

5. What is your current level of activity?
□1 Bedridden □2 Primarily no activity □3 Light labor and light sports □4 Moderate labor and moderate sports □5 Full activities without restriction

6. How do you look in clothes?
□5 Very good □4 Good □3 Fair □2 Bad □1 Very bad

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
□1 Very often □2 Often □3 Sometimes □4 Rarely □5 Never

8. Do you experience back pain when at rest?
□1 Very often □2 Often □3 Sometimes □4 Rarely □5 Never

9. What is your current level of work/school activity?
□5 100% normal □4 75% normal □3 50% normal □2 25% normal □1 0% normal

10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
□5 Very good □4 Good □3 Fair □2 Poor □1 Very poor

11. Which one of the following best describes your pain medication use for back pain?
□5None □4Non-narcotics weekly or less (e.g., aspirin, Tylenol, Ibuprofen) □3Non-narcotics daily □2Narcotics weekly or less (e.g. Tylenol III, Lorcet, Percocet) □1Narcotics daily

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12. Does your back limit your ability to do things around the house?
$\square_5$ Never $\square_4$ Rarely $\square_3$ Sometimes $\square_2$ Often $\square_1$ Very Often

13. Have you felt calm and peaceful during the past 6 months?
$\square_5$ All of the time $\square_4$ Most of the time $\square_3$ Some of the time $\square_2$ A little of the time $\square_1$ None of the time

14. Do you feel that your back condition affects your personal relationships?
$\square_5$ None $\square_4$ Slightly $\square_3$ Mildly $\square_2$ Moderately $\square_1$ Severely

15. Are you and/or your family experiencing financial difficulties because of your back?
$\square_1$ Severely $\square_2$ Moderately $\square_3$ Mildly $\square_4$ Slightly $\square_5$ None

16. In the past 6 months have you felt down hearted and blue?
$\square_5$ Never $\square_4$ Rarely $\square_3$ Sometimes $\square_2$ Often $\square_1$ Very often

17. In the last 3 months have you taken any days off of work, including household work, or school because of back pain?
$\square_5$ 0 days $\square_4$ 1 day $\square_3$ 2 days $\square_2$ 3 days $\square_1$ 4 or more days

18. Does your back condition limit your going out with friends/family?
$\square_5$ Never $\square_4$ Rarely $\square_3$ Sometimes $\square_2$ Often $\square_1$ Very often

19. Do you feel attractive with your current back condition?
$\square_5$ Yes, very $\square_4$ Yes, somewhat $\square_3$ Neither attractive nor unattractive $\square_2$ No, not very much $\square_1$ No, not at all

20. Have you been a happy person during the past 6 months?
$\square_1$ None of the time $\square_2$ A little of the time $\square_3$ Some of the time $\square_4$ Most of the time $\square_5$ All of the time

21. Are you satisfied with the results of your back management?
$\square_5$ Very satisfied $\square_4$ Satisfied $\square_3$ Neither satisfied nor unsatisfied $\square_2$ Unsatisfied $\square_1$ Very unsatisfied

22. Would you have the same management again if you had the same condition?
$\square_5$ Definitely yes $\square_4$ Probably yes $\square_3$ Not sure $\square_2$ Probably not $\square_1$ Definitely not

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Treatment Intensity Score©

There may be one or more alternatives that may apply to you. Please choose the one you feel is most descriptive of your situation at present.

What medication are you taking for your pain?

0. None
1. Tylenol, Aspirin, Motrin, Aleve or other non-prescription pain medication
2. Prescription Anti-Inflammatory (Relafen, Celebrex, Vioxx, etc) or Muscle Relaxants (Soma, Flexeril)
3. Vicodin, Codeine
4. Medrol Dose Pack
5. Morphine Analogs (Oxycontin, MS Contin, Percocet, etc.)

How long is the pain relieved before you need medication again?

0. 24 hours or more (rarely take them)
1. 12 hours
2. 8 hours
3. 6 hours
4. 4 hours
5. Less than 4 hours

How long have you taken these medications?

0. Use them occasionally only (i.e. do not take them every day)
1. 6 weeks
2. 3 months
3. 6 months
4. 1 year
5. 2 years or more

Have you needed to seek other treatment options, specifically because of pain in your neck or back?

0. None
1. Massage therapy, Shiatsu, Yoga, Chiropractor
2. Acupuncture, Acupressure, Alternative Medicine Therapies
3. Supervised Physiotherapy and/or Pain Management Consult
4. Injections such as Nerve Root Block or Epidural Steroids
5. Spinal Cord Stimulator, Morphine Pump

How often have you had to see a Doctor, Therapist or gone to the Emergency Room, specifically because of unbearable pain (disregard any routine follow-up visits)?

0. Never
1. Once in 6 months or less
2. Once in 3 months
3. Every 6 weeks
4. Every week or 2-3 times a week
5. Needed admission to the hospital for severe pain

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****This page is for patients who have had any kind of SPINE SURGERY****

Spine Post-op Questionnaire©

1) Surgery Rating: Please circle one of the following to rate the surgery as you perceive it

   A) Excellent – All pre-operative symptoms relieved; abnormal findings improved
   B) Good – Minimal persistence of pre-operative symptoms; abnormal findings unchanged
   C) Fair – Definite improvement of some pre-operative symptoms; other symptoms unchanged or slightly improved
   D) Poor – Symptoms and signs unchanged or exacerbated

2) If a friend, relative or colleague were to have the same symptoms as you had prior to surgery would you recommend the surgery to him or her?

   A) Yes B) No

3) Please note below any persistence of symptoms or unchanged findings from the time prior to your surgery. If none, please write "none".

____
____
____

4) Please detail below any new symptoms or any further surgeries following the initial surgery on your spine. If none, write "none".

____
____
____
____
____
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