



CEDARS-SINAI MEDICAL CENTER[®]

SPINE CENTER

Neel Anand, MD, Mch Orth

Clinical Professor of Surgery
Director, Spine Trauma
Minimally Invasive Spine Surgery

444 S. San Vicente Blvd., Suite 900
Los Angeles, CA 90048
310-423-9779 ph; 310-423-9773 fax

HEALTH INSURANCE ACKNOWLEDGEMENT

Please note Dr. Anand is a private physician, a separate entity from the Cedars-Sinai Medical Center.

Dr. Anand accepts patients with all insurances, however he is not a contracted provider for most health insurances. Claims will be submitted to your insurance company and payment will be collected at an out-of-network rate.

A signed contract will be required 24 hours in advance of your appointment. An out-of-pocket payment will be collected at the time of your visit.

If your insurance company mails you a check for the claim that Dr. Anand submits, you are responsible for forwarding that payment to Neel Anand, MD, Inc.

Dr. Anand is not a Medicare provider, but he does provide consultation and surgical care to Medicare patients. The initial consultation fee to see Dr. Anand will be waived for Medicare patients.

Patients Name: _____

Insurance: _____

Patient Signature

Date



Neel Anand, MD, Mch, Orth
Clinical Professor of Surgery
Director, Spine Trauma
Minimally Invasive Spine Surgery
444 S. San Vicente Blvd., Suite 901
Los Angeles, CA 90048
Phone 310-4230-9779
Fax 310-423-9773

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.

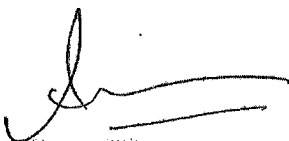
This Agreement will remain in effect until I provide Dr. Neel Anand a written notice of termination.

Patient Name: _____

Date: _____

Signature: _____

Time: _____



Neel Anand, MD

Document Handle: 43336331

Neel Anand, MD, Mch Orth

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Missed Appointment Policy

If you are unable to make your scheduled appointment, you must contact the office at 310-423-9779 to cancel the appointment at least 24 hours in advance.

Patients who do not contact the office will be charged a missed appointment fee of \$75.00.

Our staff will continue to make every effort to remind patients of their upcoming appointments, but it remains your responsibility to cancel or reschedule if you are unable to make the scheduled appointment.

Paperwork Policy

We are happy to complete forms for patients. Please note the fees associated with this service. Payment is due at the time of service and is not covered by insurance.

Initial State Disability Form	\$50.00
Continuation/Extension of State Disability Form	\$20.00
Initial Employment Disability Form	\$50.00
Continuation/Extension of State Disability Form	\$20.00
Letter of Medical Necessity	\$35.00
DMV Placard Form	\$35.00
Other Requested Correspondence	\$35.00

Telephone and Email Policy

Please allow 24 hours for our providers and staff to respond to any telephone call or email.

Medical Records Requests

All medical records and imaging are managed by Cedars-Sinai Medical Center. For copies of your medical records, please contact the Cedars-Sinai Medical Records Department at 310-423-2259. For copies of your images, please contact 310-423-9899. A written authorization to release your medical records is required.

I have read and understood these policies:

Patient/Guardian Signature

Date



CEDARS-SINAI

SPINAL SURGICAL OUTCOMES DATA REGISTRY CONSENT & AUTHORIZATION FORM

Principal Investigator:

Neel Anand, MD

Phone: (310) 423-9779

Co- investigator:

Edward Nomoto, MD Phone: (310) 423-9780

PURPOSE

Data collection and analysis related to medical records plays a key role in research. The purpose of this Spinal Surgical Outcomes data registry is to collect the medical information of as many patients as possible in order to study how different factors, such as medical history and surgical technique, affect short-term and long-term outcomes in spine surgery.

PROCEDURES

We ask for your voluntary consent and authorization to allow Dr. Anand or Dr. Nomoto and their team to review your medical record maintained by Cedars-Sinai Medical Center and copy information from your medical record into the Spinal Surgical Outcomes Registry database for research. We will collect information from your medical records to learn about factors affecting surgical outcomes. Private health information to be reviewed and abstracted from your medical record will include: Operation reports, progress notes, lab reports, questionnaire responses, x-rays and other radiology exams, medications taken, and demographics. If you sign this consent/authorization form, you are giving Dr. Anand or Dr. Nomoto and their team permission to continue to collect information from your spinal surgical medical records at Cedars-Sinai Medical Center.

CONFIDENTIALITY OF INFORMATION COLLECTED

The Spinal Surgical Outcomes data registry has a system in place to maximize the protection of your medical information. In the registry, your medical history information will be identified by a randomly assigned study number, not by your name or other personal information that identifies you. A list that contains both the assigned study number and your name and medical record number (the linking list) will be maintained separately and is only accessible to limited individuals who are approved to conduct, monitor and/or oversee this research.

The data and information gathered during this study may be used by the investigator and published and/or disclosed outside of Cedars-Sinai Medical Center in publications or other dissemination of the research data. Your identity will not be disclosed in any publication of our research findings. When we share your information for future research or with researchers at other academic institutions, we will keep your identity confidential and the information released will be identified only by a randomly assigned study number.

Information collected about you during the course of this research may be subject to inspection by CSMC departments and committees responsible for research oversight, accrediting agencies, government and regulatory groups.

By agreeing to participate in this data registry, you authorize the use and sharing of your private information indefinitely.

RISKS

Accidental breach of your confidential health information is a potential risk associated with your participation in this research registry. As noted above, Dr. Anand and his research team will take every precaution to prevent a breach from occurring. Additionally, if your confidential health information is shared with a recipient outside of Cedars-Sinai Medical Center under this Authorization, it could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, in California, the law prohibits such further disclosure of confidential health information without another signed authorization from you (unless the law specifically permits or requires the particular disclosure, such as to report suspected child abuse).

BENEFITS

Taking part in the Spinal Surgical Outcomes data registry is not intended to help you directly. However, we hope the information learned will benefit others considering spine surgery in the future by helping us to improve treatments and surgical techniques.

COMPENSATION AND COSTS

You will not be paid for your participation in the registry. There are no charges to you for collection of your data by the registry team.

PARTICIPATION

You have the right not to participate or to withdraw from this registry at any time without any penalty or loss of benefits to which you would be entitled outside of the study. You may refuse to sign this consent and authorization form. If you refuse to sign this consent and authorization form, your refusal will not affect your ability to obtain treatment at Cedars-Sinai Medical Center (CSMC).

You have the right to revoke your authorization for us to use or share your health information for this research at any time. You must contact Dr. Anand or Dr. Nomoto in **writing** to revoke your authorization. However, if you revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. Any information already obtained at the time you revoke your authorization may continue to be used as necessary to ensure study integrity.

If you have questions about this consent/authorization, or about the study, or wish to withdraw and revoke your authorization from the Spinal Surgical Outcomes data registry, please contact: Dr. Neel Anand, 444 S. San Vicente Blvd., Suite 900 Los Angeles, CA 90048, Email: anandn@cshs.org, Office: (310) 423-9779 or Dr. Edward Nomoto, 444 S. San Vicente Blvd., Suite 800 Los Angeles, CA 90048, Email: Edward.nomoto@cshs.org, Office: (310) 423-9780

If you have any questions regarding your rights, concerns, or complaints about taking part in this registry, please contact: CSMC Institutional Review Board (IRB); Phone: (310) 423-3783; Email: ResearchConcerns@cshs.org.

SIGNATURE BY THE SUBJECT:

- I have received the information concerning the Spinal Surgical Outcomes data registry and understand the risks and benefits of participation.
- I agree (consent) to enroll in the Spinal Surgical Outcomes data registry.
- I permit (authorize) the use and sharing of my data as described in this document.
- I have been given a copy of this consent/authorization form.

Name of Subject

Signature of Subject

Date of Signature

IRB No: Pro00015483/ Ame00019750

Approval Date: 5/8/2017

Expiration Date: 7/31/2017

SIGNATURE BY THE INVESTIGATOR:

I attest that all the elements of informed consent described in this form have been discussed fully in non-technical terms with the subject. I further attest that all questions asked by the subject were answered to the best of my knowledge.

Signature of the Investigator Who Obtained Consent/Authorization

Date of Signature

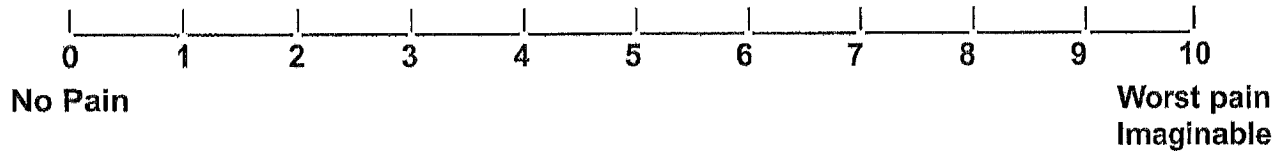


CEDARS-SINAI MEDICAL CENTER.
SPINE CENTER

PAIN DRAWING

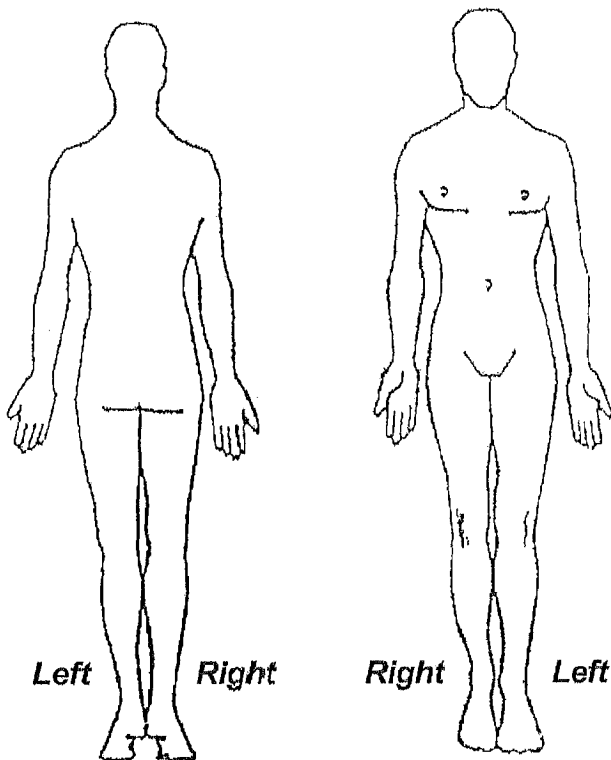
PATIENT I.D. _____

1. How much pain in general can you tolerate?



2. Where is your pain now?

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

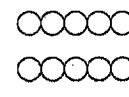


TYPE OF PAIN SYMBOL

Ache



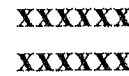
Numbness



Pins & Needles



Burning



Radiating Pain



3. How bad is your pain?

Neck pain _____ %

Arm pain _____ %

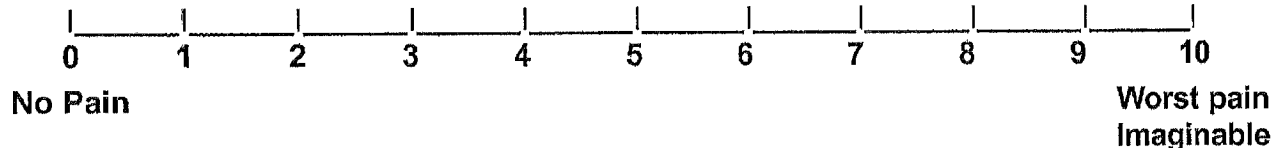
Total 100%

Back pain _____ %

Leg pain _____ %

Total 100%

4. How bad is your pain now?



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

PI/Study ID: _____

Visit Date: _____

CLINICAL EXAMINATION (PATIENT)

Patient Name:		DOB:	Gender:	Race:
Patient History				
Bowel incontinence Yes <input type="checkbox"/> No <input type="checkbox"/>		Numbness/tingling in legs Yes <input type="checkbox"/> No <input type="checkbox"/>		Leg weakness Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder incontinence Yes <input type="checkbox"/> No <input type="checkbox"/>		Loss of balance Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Bracing <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Chiropractor <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Injection – spine <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
NSAIDS <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Narcotics <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Pain program <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Physical therapy <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Other <input type="checkbox"/>	0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>		0-3mos <input type="checkbox"/> / 3-6mos <input type="checkbox"/> / 6-12mos <input type="checkbox"/> / >1yr <input type="checkbox"/>	
Past Medical History (check all that apply)				
None <input type="checkbox"/> / Alcohol/drug abuse <input type="checkbox"/> / Anemia <input type="checkbox"/> / Arthritis <input type="checkbox"/> / Blood clots <input type="checkbox"/> / Cancer <input type="checkbox"/> / Depression <input type="checkbox"/> / Diabetes <input type="checkbox"/> / Heart disease <input type="checkbox"/> / Hypertension <input type="checkbox"/> / Kidney disease <input type="checkbox"/> / Liver disease <input type="checkbox"/> / Lung disease <input type="checkbox"/> / Nervous system disorders <input type="checkbox"/> / Osteoporosis <input type="checkbox"/> / Peripheral vascular disease <input type="checkbox"/> / Psychiatric disorders <input type="checkbox"/> / Ulcers and/or stomach disease <input type="checkbox"/> / Other <input type="checkbox"/> please list: _____				
Work status (check one) Employed <input type="checkbox"/> / Disabled <input type="checkbox"/> / Retired due to back pain <input type="checkbox"/> / Retired <input type="checkbox"/> / Unemployed <input type="checkbox"/>		Level of physical labor in your job (check one) Heavy <input type="checkbox"/> / Moderate <input type="checkbox"/> / Minimal <input type="checkbox"/> / No physical labor <input type="checkbox"/>		
Do you smoke? Yes <input type="checkbox"/> / No <input type="checkbox"/>	If yes, how much do you smoke? (check one) Less than 1pk/day <input type="checkbox"/> / 1pk/day <input type="checkbox"/> / 2pk/day <input type="checkbox"/> / 3pk or more/day <input type="checkbox"/>		If quit, how long? (check one) 0-6 months <input type="checkbox"/> / 6-12 months <input type="checkbox"/> / 1yr or greater <input type="checkbox"/> / 2yrs or greater <input type="checkbox"/>	

Pt/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.

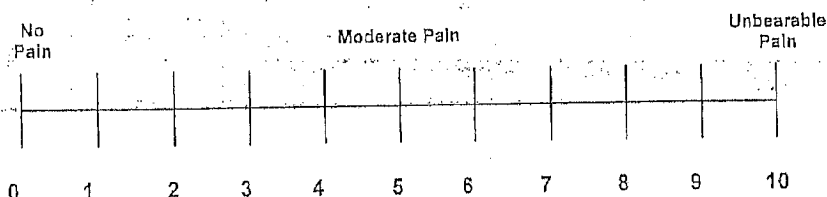
Please check one:

- ☐ 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.



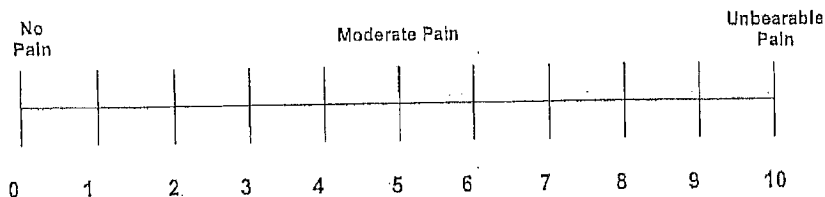
If pain, how long has Leg Pain been present?

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	<input type="checkbox"/>
The pain is very mild at the moment	<input type="checkbox"/>
The pain is moderate at the moment	<input type="checkbox"/>
The pain is fairly severe at the moment	<input type="checkbox"/>
The pain is very severe at the moment	<input type="checkbox"/>
The pain is the worst imaginable at the moment	<input type="checkbox"/>
Personal Care (Washing, Dressing, etc)	
I can look after myself normally without causing extra pain	<input type="checkbox"/>
I can look after myself normally but it causes extra pain	<input type="checkbox"/>
It is painful to look after myself and I am slow and careful	<input type="checkbox"/>
I need some help but can manage most of my personal care	<input type="checkbox"/>
I need help every day in most aspects of self care	<input type="checkbox"/>
I do not get dressed, wash with difficulty and stay in bed	<input type="checkbox"/>
Lifting	
I can lift heavy weights without extra pain	<input type="checkbox"/>
I can lift heavy weights but it gives me extra pain	<input type="checkbox"/>
Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. on a table	<input type="checkbox"/>
Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	<input type="checkbox"/>
I can only lift very light weights	<input type="checkbox"/>
I cannot lift or carry anything	<input type="checkbox"/>
Sleeping	
My sleep is never disturbed by pain	<input type="checkbox"/>
My sleep is occasionally disturbed by pain	<input type="checkbox"/>
Because of pain I have less than 6 hours sleep	<input type="checkbox"/>
Because of pain I have less than 4 hours sleep	<input type="checkbox"/>
Because of pain I have less than 2 hours sleep	<input type="checkbox"/>
Pain prevents me from sleeping at all	<input type="checkbox"/>
<p>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.</p>	
LUMBAR / LOWER BACK PAIN	CERVICAL / NECK PAIN
Walking	Headache
Pain does not prevent me walking any distance <input type="checkbox"/>	I have no headaches at all <input type="checkbox"/>
Pain prevents me from walking more than 1 mile <input type="checkbox"/>	I have slight headaches that come infrequently <input type="checkbox"/>
Pain prevents me from walking more than 1 half mile <input type="checkbox"/>	I have moderate headaches that come infrequently <input type="checkbox"/>
Pain prevents me from walking more than 1 quarter mile <input type="checkbox"/>	I have moderate headaches that come frequently <input type="checkbox"/>
I can only walking using a stick or crutches <input type="checkbox"/>	I have severe headaches that come frequently <input type="checkbox"/>
I am in bed most of the time <input type="checkbox"/>	I have headaches almost all the time <input type="checkbox"/>
Sitting	Work
I can sit in any chair as long as I like <input type="checkbox"/>	I can do as much work as I want to <input type="checkbox"/>
I can only sit in my favorite chair as long as I like <input type="checkbox"/>	I can do my usual work, but no more <input type="checkbox"/>
Pain prevents me from sitting more than one hour <input type="checkbox"/>	I can do most of my usual work, but no more <input type="checkbox"/>
Pain prevents me from sitting more than 30 minutes <input type="checkbox"/>	I cannot do my usual work <input type="checkbox"/>
Pain prevents me from sitting more than 10 minutes <input type="checkbox"/>	I can hardly do any work at all <input type="checkbox"/>
Pain prevents me from sitting at all <input type="checkbox"/>	I can't do any work at all <input type="checkbox"/>






LUMBAR / LOWER BACK PAIN	CERVICAL / NECK PAIN
Standing	Concentration
I can stand as long as I want without extra pain <input type="checkbox"/>	I can concentrate fully when I want to, with no difficulty <input type="checkbox"/>
I can stand as long as I want but it gives me extra pain <input type="checkbox"/>	I can concentrate fully when I want to, with slight difficulty <input type="checkbox"/>
Pain prevents me from standing for more than 1 hour <input type="checkbox"/>	I have a fair degree of difficulty in concentrating when I want to <input type="checkbox"/>
Pain prevents me from standing for more than 30 minutes <input type="checkbox"/>	I have a lot of difficulty in concentrating when I want to <input type="checkbox"/>
Pain prevents me from standing for more than 10 minutes <input type="checkbox"/>	I have a great deal of difficulty of concentrating when I want to <input type="checkbox"/>
Pain prevents me from standing at all <input type="checkbox"/>	I cannot concentrate at all <input type="checkbox"/>
	Reading
Sex Life (if applicable)	I can read as much as I want to, with no pain in my neck <input type="checkbox"/>
My sex life is normal and causes no extra pain <input type="checkbox"/>	I can read as much as I want to, with slight pain in my neck <input type="checkbox"/>
My sex life is normal but causes some extra pain <input type="checkbox"/>	I can read as much as I want to, with moderate pain in my neck <input type="checkbox"/>
My sex life is nearly normal but is very painful <input type="checkbox"/>	I can't read as much as I want to, because of moderate pain in my neck <input type="checkbox"/>
My sex life is severely restricted by pain <input type="checkbox"/>	I can hardly read at all, because of severe pain in my neck <input type="checkbox"/>
My sex life is nearly absent because of pain <input type="checkbox"/>	I cannot read at all <input type="checkbox"/>
Pain prevents any sex life at all <input type="checkbox"/>	
	Driving
	I can drive my car without neck pain <input type="checkbox"/>
Social Life	I can drive my car as long as I want, with slight pain in my neck <input type="checkbox"/>
My social life is normal and gives no extra pain <input type="checkbox"/>	I can drive my car as long as I want, with moderate pain in my neck <input type="checkbox"/>
My social life is normal but increases the degree of pain <input type="checkbox"/>	I can't drive my car as long as I want, because of moderate pain in my neck <input type="checkbox"/>
Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports <input type="checkbox"/>	I can hardly drive at all, because of severe pain in my neck <input type="checkbox"/>
Pain has restricted my social life and I do not go out as often <input type="checkbox"/>	I can't drive my car at all <input type="checkbox"/>
Pain has restricted my social life to my home <input type="checkbox"/>	
I have no social life because of pain <input type="checkbox"/>	Recreation
	I am able to engage in all my recreation activities, with no neck pain at all <input type="checkbox"/>
Traveling	I am able to engage in all my recreation activities, with some neck pain <input type="checkbox"/>
I can travel anywhere without pain <input type="checkbox"/>	I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck <input type="checkbox"/>
I can travel anywhere but it gives me extra pain <input type="checkbox"/>	I am able to engage in few of my recreation activities, because of pain in my neck <input type="checkbox"/>
Pain is bad but I manage journeys over two hours <input type="checkbox"/>	I can hardly do any recreation activities, because of pain in my neck <input type="checkbox"/>
Pain restricts me to journeys of less than one hour <input type="checkbox"/>	I can't do any recreation activities at all <input type="checkbox"/>
Pain restricts me to short journeys under 30 minutes <input type="checkbox"/>	
Pain prevents me from traveling except to receive treatment <input type="checkbox"/>	
On average, how bad is your LOWER BACK pain?	
<div> <div>0</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> </div> <div> <div>No pain</div> <div>Worst Pain Imaginable</div> </div>	
On average, how bad is your NECK pain?	
<div> <div>0</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> </div> <div> <div>No pain</div> <div>Worst Pain Imaginable</div> </div>	
Thank you for completing these questions!	

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
				
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> 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
				
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

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

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







PV Study ID: _____

Visit Date: _____






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

Not at all	Slightly	Moderately	Quite a bit	Extremely
				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

7. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe
					
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

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

Not at all	A little bit	Moderately	Quite a bit	Extremely
				
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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

Pt/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.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. I am as healthy as anybody I know.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. I expect my health to get worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. My health is excellent.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

THANK YOU FOR COMPLETING THESE QUESTIONS!

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

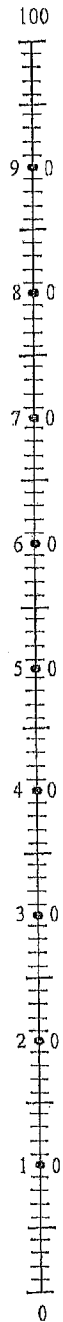
- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am extremely anxious or depressed ☐

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

SRS-22®

Page 1 of (2)

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?

- ☐₅ None ☐₄ Non-narcotics weekly or less (e.g., aspirin, Tylenol, Ibuprofen) ☐₃ Non-narcotics daily
☐₂ Narcotics weekly or less (e.g. Tylenol III, Lorcet, Percocet) ☐₁ Narcotics daily

SRS-22[®]

Page 2 of (2)

12. Does your back limit your ability to do things around the house?

☐₅ Never ☐₄ Rarely ☐₃ Sometimes ☐₂ Often ☐₁ Very Often

13. Have you felt calm and peaceful during the past 6 months?

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

14. Do you feel that your back condition affects your personal relationships?

☐₅ None ☐₄ Slightly ☐₃ Mildly ☐₂ Moderately ☐₁ Severely

15. Are you and/or your family experiencing financial difficulties because of your back?

☐₁ Severely ☐₂ Moderately ☐₃ Mildly ☐₄ Slightly ☐₅ None

16. In the past 6 months have you felt down hearted and blue?

☐₅ Never ☐₄ Rarely ☐₃ Sometimes ☐₂ Often ☐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?

☐₅ 0 days ☐₄ 1 day ☐₃ 2 days ☐₂ 3 days ☐₁ 4 or more days

18. Does your back condition limit your going out with friends/family?

☐₅ Never ☐₄ Rarely ☐₃ Sometimes ☐₂ Often ☐₁ Very often

19. Do you feel attractive with your current back condition?

☐₅ Yes, very ☐₄ Yes, somewhat ☐₃ Neither attractive nor unattractive ☐₂ No, not very much ☐₁ No, not at all

20. Have you been a happy person during the past 6 months?

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

21. Are you satisfied with the results of your back management?

☐₅ Very satisfied ☐₄ Satisfied ☐₃ Neither satisfied nor unsatisfied ☐₂ Unsatisfied ☐₁ Very unsatisfied

22. Would you have the same management again if you had the same condition?

☐₅ Definitely yes ☐₄ Probably yes ☐₃ Not sure ☐₂ Probably not ☐₁ Definitely not

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

****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".
