

DAVID A. DITSWORTH, M.D.
Neurological Surgery
Phone (310) 551-0690 Fax (310) 659-8869

Authorization for Release of Medical Records

I, _____,
Patient's name

Authorize the release of my medical records to:

DAVID A. DITSWORTH, M.D.
THE BACK INSTITUTE
920 S. ROBERTSON BOULEVARD, UNIT 6
LOS ANGELES, CALIFORNIA 90035

Records requested from:

Date (s) of Treatment: _____

Signature of patient

Date signed

Print name

Date of birth

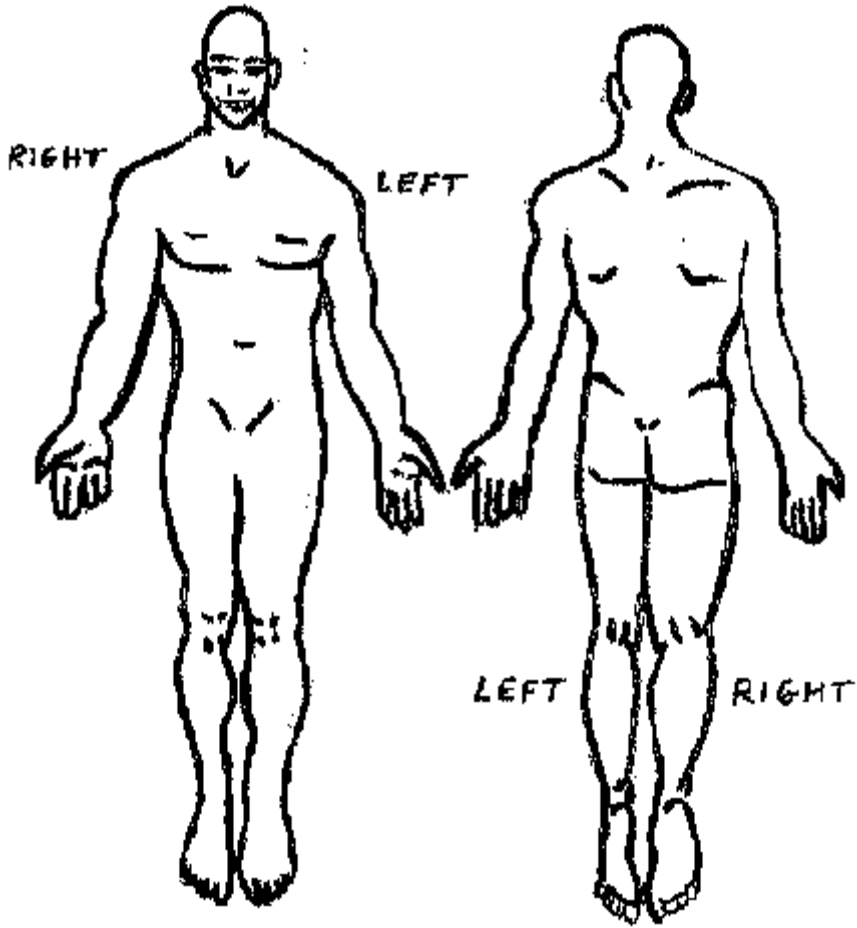
New Patient Questionnaire

Name _____
Age _____ Date _____

Medical Complaints

Please indicate the areas in which you are experiencing PAIN on the models below.

[] none



PAIN

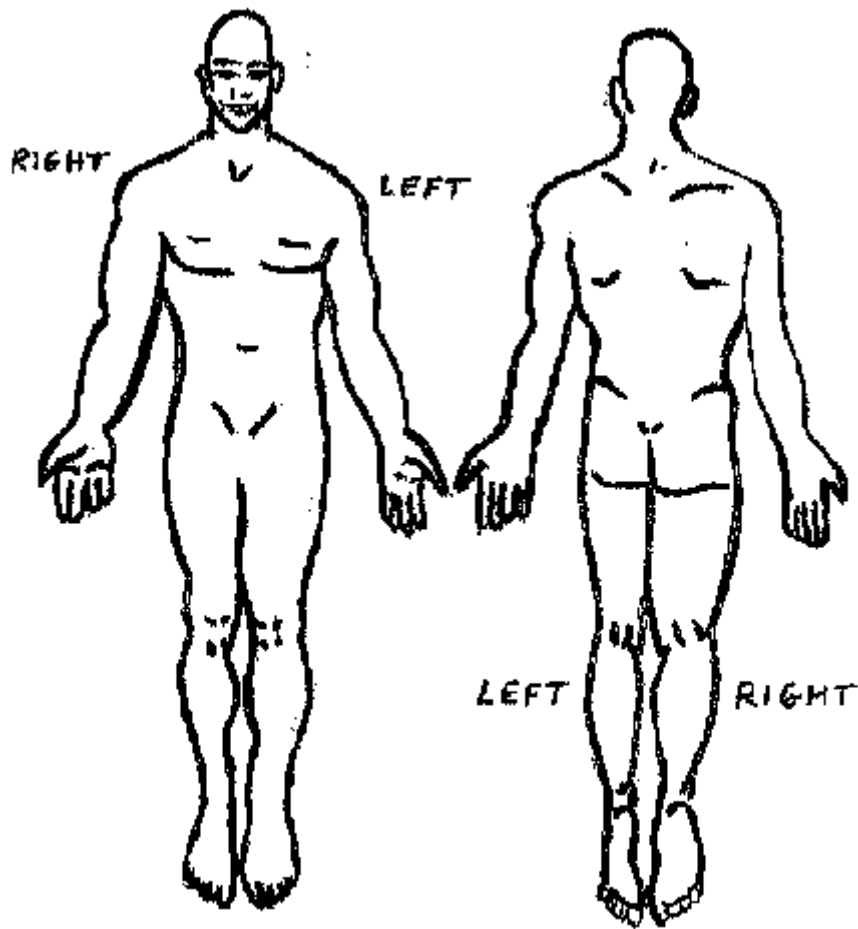
New Patient Questionnaire

Name _____
Age _____ Date _____

Medical Complaints

Please indicate the areas in which you are experiencing WEAKNESS on the models below.

[] none



WEAKNESS

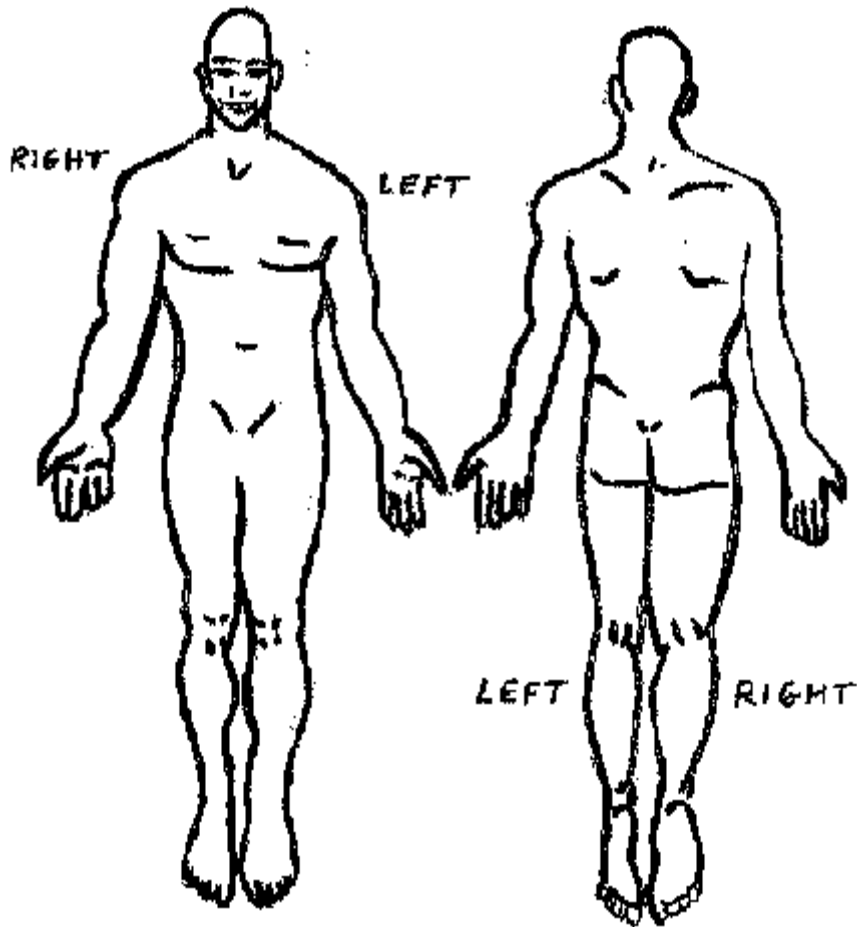
New Patient Questionnaire

Name _____
Age _____ Date _____

Medical Complaints

Please indicate the areas in which you are experiencing NUMBNESS on the models below.

[] none



NUMBNESS

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Name _____

Age _____ Date _____

Medical Complaints

1. Allergies: Is there a history of an untoward reaction to any medication and/or contrast substance such as iodine? No Yes

 If yes, please describe _____

2. What is your chief complaint? (what bothers you most?) _____

3. Describe your pain. (i.e. sharp, burning, etc.) _____

4. Does the pain go down your arm leg
 On the left right
 Down the back front

5. Do you have numbness? _____ Where? _____
Do you have weakness? _____ Where? _____

6. Have you noted any color changes of the skin? Arms Legs Feet
 If so, please describe _____

7. Have you noted any swelling of the skin? Arms Legs Feet
 If so, please describe _____

8. Does anything make the pain worse? _____

9. Have you had any bowel or bladder changes? _____

10. Have you ever had spine surgery? _____

11. Have you had any prior problems with your neck or back? yes no
 Symptoms _____

12. Have you had any prior treatments to neck or back? yes no
 If yes, please describe _____

13. What do you think caused the problem? _____

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Name _____

Age _____ Date _____

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____
ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Please list all medical conditions that you have had in the past ?

OPERATIONS:

Have you had any surgery?No Yes

INJURIES: Have you had any major injuries? No Yes

If yes, please describe _____

FAMILY HISTORY: Is there any major disease or illness that runs in your family No Yes

If yes, please describe _____

SOCIAL HISTORY:

Marital Status: _____

Do you Smoke? No Yes If yes, how much and what? _____

Alcoholic Beverages? No Yes If yes, how much and what? _____

SYSTEMIC REVIEW: Have you had any problem with any of the following?

Skin	No	Yes	_____
Head-Eyes-Ears-Nose-Throat	No	Yes	_____
Neck	No	Yes	_____
Lungs	No	Yes	_____
Genitourinary	No	Yes	_____
Blood	No	Yes	_____
Heart	No	Yes	_____
Gastrointestinal	No	Yes	_____
Locomotor-Musculoskeletal	No	Yes	_____
Neuro-Psychiatric	No	Yes	_____
Women's health	No	Yes	_____

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor

Date

Signature of patient

Name: _____ Today's Date: _____

Date of Birth: _____ Phone # _____ Examiner: _____

THE OSWESTRY* LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your *low back and/or leg pain* has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but

**PLEASE JUST CIRCLE THE ONE CHOICE WHICH CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.
PLEASE FAX THIS FORM TO (310)-659-8869 AFTER YOU HAVE COMPLETED IT.**

SECTION 1--Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2--Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 --Walking

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

*Modified with "and/or leg pain".

SECTION 6 -- Standing

- A. I can stand as long as I want without pain
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from social life at all.

SECTION 9--Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms off travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Disability index score: _____ % Evaluator:

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Insurance Information

Insurance coverage #1 :

Insurance company _____ Phone () _____

Billing address _____

Group # _____ ID # _____

Cardholder's name _____

Relationship to the patient _____

Insurance coverage # 2:

Insurance company _____ Phone () _____

Billing address _____

Group # _____ ID # _____

Cardholder's name _____

Relationship to the patient _____

Notify in emergency _____ Phone () _____

Address _____

Relationship _____

Previous physician _____

I hereby agree to pay for the services to be rendered to the above-mentioned patient and, if litigation is necessary to enforce payment, to pay a reasonable attorney or collection fee.

Date _____ Relationship, if any, to the patient _____

Address _____

Signature