DANIEL S. YANNI, MD
NEUROSURGEON &
SPINE SURGEON

Disc Comfort, Inc.
1501 Superior Ave, Suite 214
Newport Beach, CA 92663
(949) 515-0051 office (949) 515-0052 fax
www.yannimd.com

Patient Information

Thank you for taking the time to fill out this confidential patient information form.

Name: _____ **Sex: Male [ ] Female [ ]**

Date of Birth: ____/____/____ **Age:**_____ **SS#:** _____

Address: _____

City, State, Zip: _____

Phone: _____ **Marital Status:** _____

Who is referring you to our practice? _____

Who is your Primary Care Physician? _____

Emergency Contact: _____ **Relationship:** _____
Phone: _____ **Other Phone:** _____

Guarantor same as patient [ ] Yes [ ] No If not, Please fill out Guarantor information:
Name: _____ **Date of Birth:** _____/_____/_____
Address: _____
SS# _____ **Employer:** _____
Phone: _____ **Other Phone:** _____

I hereby authorize and consent to examination and treatment as deemed necessary by physicians and allied medical practitioner of Disc Comfort, Inc.

I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Disc Comfort, Inc. in the collection of amounts due including, but not limited to, reasonable attorney's fee. I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Disc Comfort, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

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I, the undersigned, understand that payment for all care received is my responsibility.

For clinical appointments, I understand that a 24-hour cancellation notice is necessary to avoid charges. A $75 fee is charged for cancellations made with less than 24 hours' notice and for missed appointments.

For any paperwork, I understand that a $50 fee is charged for any forms that need to be filled out, including disability forms after surgery.

For surgical scheduling, I understand that there will be a $200 fee to change dates of surgery with less than two-weeks' notice from the tentatively agreed upon surgical date. I also understand that three will be a $500 fee for cancellation of surgery within two weeks of tentatively agreed upon surgical date. I also understand that my tentatively agreed upon surgical date may be moved or cancelled by the office at any time, in which circumstance, I would not incur a rescheduling or cancellation fee.

Today's Date: ____ / ____ / _____

Patient (Guardian) Signature: _____

Patient (Guardian) Name (Please Print): _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our goal is to provides excellent patient care and we are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

WE ACCEPT CASH AND MOST MAJOR CREDIT CARDS

Regarding Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the patient's information form.

PPO Plans (with which we are contracted): We have agreed to take a discount from your insurance company. Your co-insurance is your responsibility and is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider you will be responsible for any out of network deductible or coinsurance amounts.

Medicare: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will be your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for the balance of which Medicare or your secondary does not pay.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cash Patient

All services must be paid in full at time of treatment.

Administrative Fee

All co-pays will be collected at the time of service. If a patient does not submit payment at the time of service, the patient will be billed for the co-pay and a $15 Administrative Fee will be added. In addition, any patient invoices that are not paid within thirty days of the invoice date, a $75 fee will be added to the current bill.

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Benefit Reassignment Agreement

Below please find the benefit reassignment agreement policy of Disc Comfort Inc. regarding payments for services.

I, _____, hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering services. I understand that I am financially responsible for the charges not covered by my medical insurance policy. I understand that is my responsibility as the patient to become familiar and understand coverage of services and benefits under my insurance plan. I hereby authorize the doctor providing medical service to release any information required any insurance carries services rendered by Disc Comfort Inc. are the stole property of Disc Comfort Inc. I agree not to cash those payments and to submit them directly to Disc Comfort Inc. within one week of receiving such payments.

Please do not hesitate to contact our staff with any questions or comments regarding the document.

By signing this document, I understand both the Financial Policy and the Benefit Reassignment Agreement with Disc Comfort Inc.

Name (Please Print): _____

Signature: _____

Date: ____/_____/_____

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Patient Privacy Policy Notice

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

On file and display in our office(s) is our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- **Our Pledge**
- **Your Personal Information**
- **Our Privacy Practices**
- **How we may us or share your information for:**
  - **Treatment**
  - **Payment**
  - **Health Care Options**
  - **Notifications**
  - **Marketing**
  - **Research**
- **Special Circumstances and the Law**
  - **Your written Permission**
  - **Other Restrictions**
  - **Your Rights**
  - **Changes**
- **Questions or Complaints**

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should be available to you, as required by law. If you wish to keep a copy of our Notice of Privacy Practices, please let the receptionist know when you check in to see the Doctor.

We asked that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have presented for your review a paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipts of the Notice of Privacy Practices:

_____	_____	_____
Signature	**Name**	**Date**

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Controlled Substance Agreement

I understand that my provider is prescribing controlled medications (opioids, barbiturates, benzodiazepines) to assist me in managing my post-operative pain. These medicines are intended to decrease pain in order to improve function and allow progress in rehabilitation. As the user of the medications, I understand that I have important responsibilities regarding the care and use of these medications. The risks, benefits, and side effects of these medication have been explained to me and I agree to the following conditions for this type of treatment.

1. **I understand that I should be receiving pain medication from only one doctor or practice at any one time. I understand that I will be only getting prescriptions for pain medicines from Dr. Yanni or from a physician outside of the practice, but NOT BOTH. If I develop another condition that requires from prescription of a controlled medication. I will inform the clinic within one business day of receiving any new controlled medication.**
2. **I understand that Dr. Yanni may only be prescribing my pain medication up to 90 days past the date of my surgery. At that point, if they are still necessary. I will receive them from my PCP or a dedicated pain management physician.**
3. **I will designate only one pharmacy where all of my narcotic prescriptions will be filled.**
4. **I will take my medications exactly as prescribed and will not changed the medication dosage or schedule without my provider's approval. Refills may not be given if I "ran out early."**
5. **I understand that I am responsible for the care of my medication once I leave the office/hospital with my prescription. I understand that my narcotic medications may not be replaced if they are lost, stolen, or destroyed. Controlled medication should be locked up and secured.**
6. **Refills of controlled medication will be made only during regular office hours.**
7. **I understand that the medications prescribed are for the sole purpose of pain control and agree not to use it for any other purpose.**
8. **I will not share or divert my narcotic medications with any other person.**
9. **I understand that controlled medications can affect my thinking and judgment and may interfere with my ability to drive. I will not drive if I have this concern.**
10. **I understand that my physician may use a prescription monitoring program to keep track of my medications.**

I understand these rules and that noncompliance may lead to the discontinuation of my medication and/or discharge from Dr. Yanni's care. I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency. Including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

I authorize my doctor to provide a copy of this Agreement to my pharmacy.

I agree to waive any application or right of privacy or confidentiality with respect to these authorizations.

I have read the contract and it has been explained to me. I fully understand the consequences of violated the agreement.

Patient Name	Signature	Date

New Patient History

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

Visit Date (mm/dd/yy): ____ / ____ /____ **Name: (Last, First):**_____

Date of birth (mm/dd/yy): _____ / ____ /____ **Age:** _____ **Sex:** [ ] Male [ ] Female

Who referred you to this office?

☐ Referring Doctor: _____ Address:_____ Phone:_____
☐ Primary Physician: _____ Address:_____ Phone:_____
☐ Self- Referral

A. Symptoms & Pain Assessment

1. Chief Complaint: _____

2. How long have you had these symptoms? ____Days ____ Weeks ___ Months ___ Years

3. Describe the quality of your pain (Please check in the box)

☐ Burning ☐ Sharp ☐ Shooting ☐ Tingling ☐ Numbness

☐ Pinprick ☐ Stabbing ☐ Deep-Pressure ☐ Tightness ☐ Spasms

☐ Other (Please describe) _____

4. How often do you experience the pain?

☐ Constant ☐ Intermittent ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____

5. How did your pain start? ☐ Gradually ☐ Suddenly

What day did your pain start?_____

6. Since the pain began, is it ☐ Worse ☐ Better ☐ Unchanged?

7. Does the pain radiate to..... An arm? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

Or a leg? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

Do you have weakness in..... An arm? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

Or a leg? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

Do you have numbness in.... an arm? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

Or a leg? ☐ No ☐ Yes If yes: ☐ Right ☐ Left ☐ Both

8. Any changes in bowel or bladder function?

☐ **No** ☐ **Yes –** ☐ Bowel Incontinence ☐ Constipation ☐ Hesitancy ☐ Other _____

MD Initial: _____ Date: _____ Time:_____

New Patient History

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

9. Was there any injury/event that caused your pain?

☐ **No** ☐ **Yes – Date of injury(mm/dd/yy): ___ / ___ / ____**

Pleas describe how you were injured: _____

_____

A. Legal action pending? ☐ No ☐ Yes

B. Work related? ☐No ☐Yes

Employer at time of injury:_____

Job Title: _____

Worker's Compensation? ☐No ☐Yes- Name of your attorney: _____

10. Any prior back or neck injury/pain before the event about?

☐No ☐Yes – What type? (Please describe)_____

How severe is your pain today?

(Please circle the number to indicate how bad you feel your pain is today.)

No pain ---------- Worst Pain

0 1 2 3 4 5 6 7 8 9 10

11.Pain Rating

Please rate your *Average* level of pain on the following scale (circle one)

No pain ---------- Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Please rate your *Worst* level of pain on the following scale (circle one)

No pain ---------- Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Please rate your *Best* level of pain on the following scale (circle one)

No pain ---------- Worst Pain

0 1 2 3 4 5 6 7 8 9 10

MD Initial: _____ Date: _____ Time:_____

New Patient History

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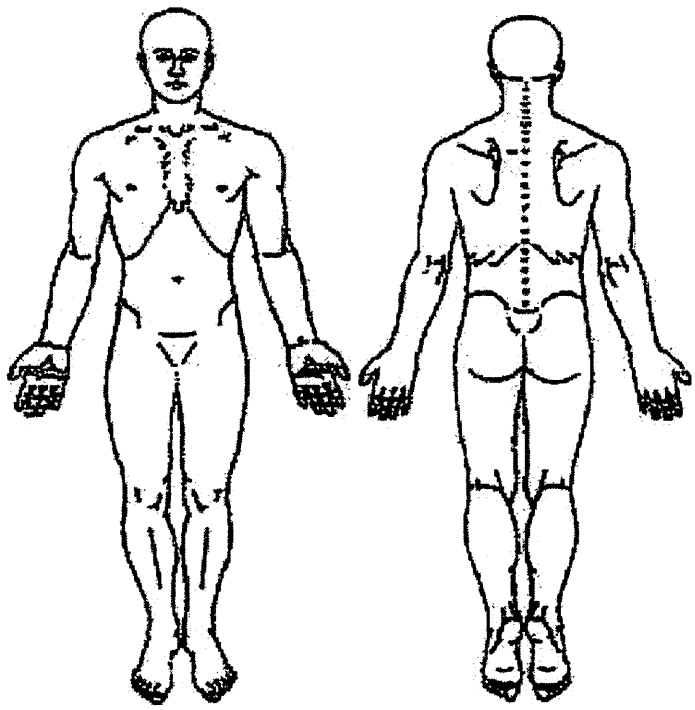
Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

Using the symbols given below, mark the area on your body where you feel the described sensation include all affected areas.

Numbness = = = **Pins & Needles 000** **Burning xxx** **Stabbing ///** **Aching (((**



12. Do you have pain at night?

☐No ☐Yes – Does your pain wake you up from your sleep? ☐No ☐Yes

13. What makes your pain better?

☐Sitting ☐Standing ☐Bending ☐Laying Down ☐Walking ☐Epidural Injection

☐Nerve Blocks ☐Physical Therapy ☐ Acupuncture ☐ Message ☐Chiropractic

☐Medication

☐Other _____

14. What makes your pain worse?

☐Sitting ☐Standing ☐Bending ☐ Lying Down ☐Walking

☐Neck Movement ☐ Coughing/Sneezing

☐Other _____

MD Initial: _____ Date: _____ Time:_____

New Patient History

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

B. Previous Treatment & Evaluation

1. What diagnostic test have you had for this problem?

☐X-ray ☐MRI ☐CT ☐EMG ☐Bone Scan ☐Myelogram ☐ Blood/Laboratory

2.Please check any of the following if you have tried for your pain or discomfort:

☐Surgery ☐ TENS ☐Epidural Injections ☐ Nerve Blocks ☐Physical therapy ☐Acupuncture

☐Massage ☐Anti-inflammation medications ☐Chiropractic ☐Other_____

a. Which treatment have you tried for your pain or discomfort is the best treatment?

_____

C. Medical/Surgical History

1. Please list other medical problems (Please check in the box)

☐ High Blood Pressure ☐ Arthritis ☐ Diabetes ☐ Heart Disease- type:_____

☐ Stroke ☐ Osteoporosis ☐High Cholesterol ☐ Cancer- type:_____

☐ Thyroid ☐ Asthma ☐ Stomach Ulcer ☐ Kidney stones ☐ Blood Clots in leg

☐ Depression ☐ AIDS/HIV ☐ Other_____

2. Have you ever had <u>spine-surgery</u> in the past? ☐ No ☐ Yes

Type of spine surgery: _____ Date: _____

_____Date: _____

_____ Date: _____

3.Please list other non-spinal surgery: _____Date: _____

_____Date: _____

_____Date: _____

D. Family Medical History

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer

Mother Age: _____ ☐ Healthy ☐ Deceased due to:_____

Father Age: ____ ☐ Healthy ☐ Deceased due to:_____

Brother/Sister Age: _____ ☐ Healthy ☐ Deceased due to:_____

Age: _____ ☐Healthy ☐ Deceased due to:_____

E. Social History

MD Initial: _____ Date: _____ Time:_____

New Patient History

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Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Number of children:_____

E. Social History

Do you drink alcohol? ☐ No ☐ Yes if Yes, how much? _____

Do you smoke? ☐No ☐ Yes if Yes, how much? _____

Do you use recreational substances? ☐ No ☐ Yes if Yes, Type and Frequency: _____

Are you currently working?

☐ No ☐ Yes Employer:_____Job Title:_____

How long have you worked there? _____ Days _____Weeks _____ Months _____Years

Length of time on job: _____ hours/day _____ days/week

Movements required for your job

☐ twisting ☐ pulling ☐ pushing ☐ sitting ☐ standing ☐ stopping ☐ crawling ☐ lifting ___pounds ☐ reaching

☐bending ☐crouching ☐ grasping ☐ balancing ☐ squatting ☐ kneeling ☐ climbing stairs ☐ climbing ladder

Sitting time:_____hours/day standing time:_____hours/day

Are you able to preform your usual duties? [ ]No [ ]Yes

F. Review of Systems

Skin
- ☐ Skin rash
- ☐Easy bruising
- ☐Abnormal hair loss

Neurological
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Paralysis

Eyes
- ☐ Visual loss
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Glasses/contacts

Bone/Joint Muscles
- ☐ Muscle wasting
- ☐ Muscle Cramping
- ☐ Joint pain

Ear/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐Vertigo/Dizziness
- ☐Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐Painful Urination
- ☐Kidney Stones
- ☐Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous Breakdown
- ☐Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐Asthma/Bronchitis
- ☐ Cough
- ☐Tuberculosis
- ☐Pneumonia
- ☐ Emphysema/COPD

Gastrointestinal
- ☐Appetite Change
- ☐Jaundice
- ☐ Irritable bowels
- ☐Nausea/vomiting

Endocrine
- ☐Goiler
- ☐Heat/Cold intolerance
- ☐Increased thirst
- ☐Increased size of hand or feet

Cardiovascular
- ☐Palpitations
- ☐Chest pains
- ☐Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐Fever/chills
- ☐Weight loss
- ☐ Weight Gain
- ☐ Fatigue

Blood system
- ☐Anemia
- ☐Bleeding tendency
- ☐Bruising

MD Initial: _____ Date: _____ Time:_____

New Patient History

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Medication

1. Do you have any Allergies to medication, food or latex?

☐ No known allergies

☐ Yes – Allergies:_____Reaction:_____

Allergies:_____Reaction:_____

Allergies:_____Reaction:_____

Allergies:_____Reaction:_____

Allergies:_____Reaction:_____

2. Current Medication

☐ No ☐ Yes, list below:

Medications	Dose	Route	Frequency	Time & Date Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

MD Initial: _____ Date: _____ Time:_____

New Patient History

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SF-12 v. 2 Health Survey

This Survey ask you 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.

Answer every question by selecting the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1 In general, would you say your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. 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 limited at all
a. moderate activity, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. climbing several flights of stairs	☐	☐	☐

3.Durning 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.Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the kind of work or activities	☐	☐	☐	☐	☐

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 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. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

5. 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

MD Initial: _____ Date: _____ Time:_____

New Patient History

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Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

6.These questions are about how you feel and how thing have been with during the past 4 weeks. For each question, please give the one answer that come 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 the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b.Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐

7. 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
☐	☐	☐	☐	☐

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Oswestry Questionnaire

How long have you had back pain? ____Years _____Months _____Weeks _____Days

How long have you had leg pain? ____Years ____Months _____Weeks _____Days

This Questionnaire has been designed to give the doctor information as to how your back pain has affect your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most clearly describes your problem.

Section 1-Pain Intensity

[] I can tolerate the pain I have without pain killers
[] The pain is had but I manage without pain killers
[] Pain killers give complete relief from pain
[] Pain killer give moderate relief from pain
[] Pain killers give very little relief from pain
[] Pain killers have no effect on the pain

Section 2 -Personal Care (Washing, Dressing)

[] I can look after myself normally without causing pain
[] I can look after myself normally but cause more pain
[] It is painful to look after myself and I am slow
[] I need some help but manage most of my personal
[] I need help every day in most aspects of self-care
[] I do not get dressed, I wash with difficulty and I stay in bed

Section 3 -Lifting

[] I can lift heavy weights without extra pain
[] I can lift heavy weights but it gives extra pain
[] Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned on a table
[] Pain prevents me from lifting heavy weights but I can manage light weights
[] I can lift only very light weights
[] I cannot lift or carry anything at all

Section 4 – Walking

[] Pain doesn't prevent me from walking
[] Pain prevent me from walking more than 1 mile
[] Pain prevent me from walking more than ½ mile
[] Pain prevents me from walking more than ¼ mile
[] I can only walk using a stick or crutches
[] I am in bed most of the time & crawl to the toilet

Section 5 -Sitting

[] I can sit in any chair as long as I like
[] I can only sit in my favorite chair(s) as long as I like
[] Pain prevents me from sitting more than 1 hour
[] Pain prevents me from sitting more than ½ hour
[] Pain prevents me from sitting more than 10 min
[] Pain prevents me from sitting at all

Section 6- Standing

[] I can stand as long as I want without extra pain
[] I can stand as long as I want but it gives me pain
[]Pain prevents me from standing for more than 1 hour
[]Pain prevents me from standing for more than 30 min
[]Pain prevents me from standing for more than 10 min
[]Pain prevents me from standing at all

Section 7-Sleeping

[]Pain does not prevent me from sleeping well
[]I can sleep well only by using tablets
[]Even when I take tablets I have less than 6 hours sleep
[]Even when I take tablets I have less than 4 hours sleep
[]Even when I take tablets I have less than 2 hours sleep
[] Pain prevents me from sleeping at all

Section 8 -Sex Life

[] My sex life is normal and cause 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 severally restricted by pain
[] My sex life is nearly absent because of pain
[] Pain prevents any sex life at all

Section- 9 Social life

[]My social life is normal and gives me no pain
[]My social life is normal but increase the degree of pain
[]Pain has no significant effect on my social life apart from limiting my more energetic interests
[]Pain has restricted my social life & I do not go out often
[]Pain has restricted my social life to my home
[]I have no social life because of pain

Section 10- Traveling

[] I can travel anywhere without extra pain
[] I can travel anywhere but it gives me extra pain
[] Pain is bad but I manage journeys over two hours
[] Pain restricts me to journeys of less than one hour
[] Pain restricts me to short necessary journeys under 30 min
[] Pain prevents me from traveling except: to the doctor or hospital

MD Initial: _____ Date: _____ Time:_____

New Patient History

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

Neck Pain and Disability Questionnaire (Vernon-Mior)

This Questionnaire has been designed to give the doctor information as to how your back pain has affect your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most clearly describes your problem.

Section 1-Pain Intensity

[] I have no pain at the moment
[] The pain is very mild at the moment
[] The pain is moderate at the moment
[] The pain is fairly severe at the moment
[] The pain is very severe at the moment
[] The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, Dressing)

[] I can look after myself normally without causing pain
[] I can took after myself normally but it causes extra pain
[] It is painful to look after myself and I am slow & careful
[] I need some help but manage most of my person care
[] I need help every day in most aspects of self-care
[] I do not get dressed, I wash with difficulty & stay in bed

Section 3 -Lifting

[] I can Lift heavy weights without extra pain
[] I can lift heavy weights but it cause extra pain
[] Pain prevents me from lifting heavy weights off Floor, but I can manage if they are conveniently Positioned on a table
[]Pain prevents me from lifting heavy weights but I can manage light weights
[] I can lift only very light weights

Section 4 – Reading

[] I can read as much as I want with no neck pain
[] I can read as much as I want with slight neck pain
[] I can read as much as I want with moderate pain
[] I can't read as much as I want because of pain
[] I can hardly read at all because of server pain
[] I cannot read at all

Sections 5- Headaches

[] I have no headaches at all
[] I have slight headaches that come infrequently
[] I have moderate headaches that come infrequently
[] I have moderate headaches that come frequently
[] I have severe headaches that come frequently
[] I have headaches almost all of the time

Section 6- Concentration

[] I can concentrate fully when I want with no difficulty
[] I can concentrate fully when I wasn't with slight difficulty
[] I have a fair degree of difficulty concentrating when I want
[] I have a lot of difficulty in concentrating when I want to
[] I have a great deal of difficulty concentrating when I want
[] I cannot concentrate at all

Section 7-Work

[] I can do as much as I wan
[]I can do my usual work but no more
[] I can do most of my usual work but no more
[] I cannot do my usual work
[] I can hardly do any work at all
[] I can't do any work at all

Section 8- Driving

[] I can drive my car without any neck pain
[] I can drive my car as long as I want with slight
[] I can drive my car as long as I want with moderate pain
[] 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 the server pain in my neck
[] I cant drive my car at all

Section 9 -Sleeping

[] I have no trouble sleeping
[] My sleep is slightly disturbed (less than 1 hr. sleepless)
[] My sleep is mildly disturbed (1-2 hours sleepless.)
[] My sleep is moderately disturbed (2-3 hours sleepless)
[] My sleep is greatly disturbed (3-5 hour sleepless)
[] My sleep is completely disturbed (5-7 hours sleepless)
[] My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation

[] I am able to engage in all my recreation activities with no pain
[] I am able to engage in all my recreation activities with some pain
[] I am able to engage in most but not all of my usual recreation a activities because of neck pain
[] I am able to engage in all few of my usual recreation activities because of neck pain
[] I hardly do any recreation activities because of pain
[] I can't do recreation activities at all

MD Initial: _____ Date: _____ Time:_____