Welcome to THE ORTHOPAEDIC CENTER OF NEW JERSEY. We want to insure that you are provided with the highest standard and quality of care for your spinal problem(s).

THE ORTHOPAEDIC CENTER GOALS

1. TO REDUCE YOUR BACK PAIN TO A TOLERABLE LEVEL THAT WILL ALLOW YOU TO RETURN TO ACTIVITIES OF DAILY LIVING. This could include a return to work, but may not be the same work you were doing before the onset of your problems.

2. WE WILL PROVIDE CARE WITH CONSERVATISM AS OUR GUIDE. We will evaluate and treat you using the least invasive measures necessary to provide relief of your complaints.

3. WE WILL UTILIZE THE APPROPRIATE DIAGNOSTIC TESTING TO ISOLATE THE CAUSE OF YOUR PAIN, WHETHER ACUTE OR CHRONIC AND OFFER AN APPROPRIATE COURSE FOR THE RESOLUTION OF THE PROBLEM. WE WILL NOT PROVIDE NARCOTICS FOR CHRONIC PAIN. If a cause for the chronic pain cannot be found, then a referral to experts in the management of chronic pain will be recommended. These experts will be responsible for your medications and all refills.

4. MEDICAL REFILLS WILL BE PROVIDED DURING OFFICE HOURS ONLY. Please take responsibility for your medications. Do not forget holidays or if you are going on vacation...plan ahead! Refills may be called in from 9:00 a.m. through 5:30 p.m. The answering service will take a message for refills, but the refills will be handled on the next working day. Please also remember that most narcotic pain medication will not be accepted over the phone by most pharmacies.

5. YOUR TIME IS VALUABLE...WE WILL TRY TO BE ON TIME, BUT BACK PROBLEMS ARE UNPREDICTABLE AND YOU MAY REQUIRE MORE TIME THAN ALLOCATED. If we are behind, it is because someone before you had a complicated problem and required more time. You will not be rushed, and we will do our best to answer all your questions.

To understand your problems we need to know your history. The Spine Questionnaire will provide us with accurate information in your words about your problem. The questions are a guide to insure critical information is not missed. This spine questionnaire is your chance to insure that we have an accurate history. This history will become a permanent part of your record.

PLEASE KEEP THIS FOR YOUR REFERENCE AND THANK YOU FOR CHOOSING THE ORTHOPAEDIC CENTER OF NEW JERSEY.

Marc I. Malberg, M.D.
Orthopaedic Spine Surgeon
I. MY PROBLEM IS: (Check all which apply)
   A. _____ low back pain
      1. _____ low back stiffness
      2. _____ low back aching
      3. _____ pain mostly in the buttock  _____ right  _____ left
      4. _____ pain mostly in the leg  _____ right  _____ left
      5. _____ numbness in leg or foot  _____ right  _____ left
      6. _____ pain in the neck
      7. _____ stiffness in the neck
      8. _____ aching in the neck
      9. _____ pain in the shoulder  _____ right  _____ left
     10. _____ numbness in the arm  _____ right  _____ left
     11. _____ neck or back problem which is now quiet, but want an evaluation

II. MY PROBLEM BEGAN:
   12. _____ gradually over time; has been present for  _____ months  _____ years
   13. _____ this present episode started on  
   14. _____ problems off and on which suddenly got worse on

III. MY PAIN IS DUE TO AN INJURY AT:
   A. Work (If not work related, skip to IV.)
      1. _____ while or after lifting
      2. _____ while or after carrying
      3. _____ after a fall
      4. _____ while twisting
      5. _____ after slipping
      6. _____ other (describe)
      7. _____ do not remember

IV. MY PAIN IS DUE TO A MOTOR VEHICLE ACCIDENT: (If not MVA related, skip to V.)
   A. I was the
      1. _____ driver
      2. _____ passenger
      3. _____ wearing a seat belt
      4. _____ not wearing a seat belt
B. My vehicle was hit
1. _____ in the rear end
2. _____ head on
3. _____ passenger side
4. _____ driver side

C. My vehicle was
1. _____ at a complete stop
2. _____ slowing down
3. _____ acceleration from a stop
4. _____ other ________________________________

D. I received emergency care
5. _____ at the scene
6. _____ taken to an Emergency Room at ___________________________ Hospital
7. _____ no treatment
8. _____ other ________________________________

V. MY INJURY IS RELATED TO:
A. Sports (If not related, skip to VI.)
1. _____ running
2. _____ training with weights
3. _____ team sports
4. _____ individual sports
   Circle: football basketball baseball soccer other ________________

VI. PLEASE RATE YOUR PAIN TODAY

<table>
<thead>
<tr>
<th>no pain</th>
<th>mild pain</th>
<th>moderate pain</th>
<th>severe pain</th>
<th>very severe pain</th>
<th>worst pain ever</th>
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<tbody>
<tr>
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<td>0-</td>
<td>1</td>
<td>2------------</td>
<td>3</td>
<td>4--------------</td>
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VII. BOWEL AND BLADDER CONTROL
A. _____ I have had no change in my bowel or bladder control.
2. _____ I have difficulty controlling my bladder since my back problems started.
3. _____ I have difficulty controlling my bowels since my back problems started.

VIII. I FEEL BETTER: (Check all that apply.)
1. _____ lying on my back
2. _____ lying on my side
3. _____ lying on my stomach
   _______ right          _______ left
4. _____ keep changing positions
IX. I FEEL WORSE DOING THE FOLLOWING: (Check all that apply)
1. _____ driving
2. _____ bending
3. _____ walking
4. _____ coughing or sneezing
5. _____ lifting
6. _____ rainy or cold weather

X. MY PROBLEM IS:
1. _____ more in the back than in the leg(s)
2. _____ more in the leg(s) than in the back
3. _____ equal between the back and the legs

XI. PLEASE LIST THE FOLLOWING X-RAYS OR TESTS DONE ON YOUR BACK AND THE APPROXIMATE DATE THAT THEY WERE DONE:

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE WHEN DONE</th>
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XII. I HAVE BEEN TREATED FOR MY BACK PROBLEM IN THE PAST: Circle: Yes   No
A. Please list name of doctor/surgeon(s)__________________________

XIII. I HAVE HAD THE FOLLOWING TREATMENT FOR MY BACK: (Check all that apply.)
4. _____ physical therapy
   1. _____ heat/ultrasound/electrical stimulation
   2. _____ exercises
   3. _____ traction
5. _____ medications
   1. _____ anti-inflammatory
   2. _____ pain
   3. _____ muscle relaxants
   4. _____ over-the-counter
6. _____ previous surgery (Please list type of surgery and approximate date.)

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<tr>
<th>SURGERY</th>
<th>DATE WHEN DONE</th>
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XIV. MY PRIMARY LANGUAGE IS ENGLISH:
  _____ YES    _____ NO  (If no, please state)

XV. EDUCATION:
A. _____ high school diploma or equivalent
2. _____ undergraduate college degree
3. _____ graduate or professional degree
4. _____ vocational or associate degree
THE ORTHOPAEDIC CENTER OF NEW JERSEY
THE SPINAL INSTITUTE OF NEW JERSEY

PAIN DRAWING

Please mark areas on the body where you have experienced abnormal feelings. Use the symbols listed below and include all the affected areas. If you use the symbol for “other,” please let us know what that feeling is.

PAIN
++++

ACHE
AAAA

NUMBNESS
OOOO

PINS & NEEDLES
●●●●●

OTHER
XXXX

---End---