200, 1402 8th Avenue N.W.
Calgary, AB T2N 1B9
Phone: 403.452.4798
Fax: 403.452.0995

COVER PAGE

Attention:

Name: _____

FROM:

CALEO Health Spine

Spine Assessment Questionnaire

Booking Coordinator – Caleo Health
(403) 452-4798

Riley Park Village
200 – 1402 8th Avenue N.W.
Calgary, AB T2N 1B9

Ph: 403-452-4798
Fax: 403-452-0995
http://www.caleohealth.ca

Save then e-mail to spinetriage@caleohealth.ca
Or Print then Mail or Fax to Caleo Health

Print

Dear Patient

The questionnaire should be completed and mailed to Caleo Health along with your payment. Payment may be made by money order or bank draft for $300.00 payable to: Caleo Health. If you select to return your questionnaire by fax or secure-email you may complete your payment by credit card over the phone. *(Please note we do not accept personal cheques).*

To Avoid the Rebooking fee of $100.00 A Minimum of 48 hours notice is required for all Changes or Cancellations of appointments. A $20.00 administration fee will be applied for all refunds. There are NO Refunds for no show or late cancellation of appointments.

REFUND POLICY: ALL REFUNDS ARE SUBJECT TO A $20 ADMINISTRATION & PROCESSING FEE. Refunds will not be issued after 90 days of the initial payment date. No refunds will be issued for appointments missed or cancelled within 24 hours of the appointment date. No refunds will be issued after you have received your Spine Assessment.

Secure-Mail:
spinetriage@caleohealth.ca
Credit card payments can be made over the phone: (403) 452-4798
Fax: (403) 452-0995

Mail to:
Caleo Health
Att'n: Spine Assessment Administrator
#200, 1402 8th Avenue N.W.
Calgary, Alberta T2N 1B9

Once we have the payment your medical information will be reviewed by one of our specialist. A staff member will contact you in approximately 10 business days of the review to book the appointment.

At the time of your appointment we ask that you arrive 10 minutes early, dress comfortably, and be prepared to be on-site for approximately 1 hour.

Please read all the attached information before proceeding, and visit the Caleo Health website for more information: https://caleohealth.ca/spine-assessment-information/. Thank You!

Booking Coordinator
Caleo Health | Ph: (403) 452-4798 | Fax: (403) 452-0995

Please MAIL all Documents and Payment together

If you are sending your Questionnaire by FAX send to: Caleo Health Spine (403) 452-0995

Credit Card Payments can be made over the phone or in person: (403) 452-4798

If you are sending your Questionnaire by E-MAIL you may call to Join or Secure-Mail System

We ask that you DO NOT send your medical information via standard email this is not secure and doing so is at your own risk. Caleo Health does not take responsibility for any information you may attempt to transmit via standard email

SPINE ASSESSMENT REGISTRATION QUESTIONNAIRE
TO BE COMPLETED BY THE PATIENT PRIOR TO THE ASSESSMENT
(Please complete and forward to Caleo Health Spine Department, by Email, Fax or Mail)

Patient information

Save then e-mail to spinetriage@caleohealth.ca
Or Print then Mail or Fax to Caleo Health

Print

First Name

Last Name

Address

City

Province/State: Alberta

Postal code

Home phone number

Work phone number

Extension

Cell phone number

Email address

Health card number (PHN)

Province issued: Alberta

Please confirm your gender (sex):

Male ◯ Female ◯

Please enter your date of birth (mm/dd/yyyy): / /

Are you left or right handed?

Right ◯ Left ◯

What is your weight in pounds (lbs)?

What is your height? Feet Inches

Referring Physician's information

Name of Family Physician

Office Email Address *(if known)*

Office Phone Number *(if known)*

Office Fax Number *(if known)*

Current Condition (History of Present Illness)

Patient Name: DOB:

Area Affected: (*Select only one – the most severely affected area)*

❑ Neck ❑ Neck with arm pain ❑ Mid Back ❑ Low Back ❑ Low Back with leg pain ❑ Low Back/buttocks pain

Cause of Symptoms/Injury:

❑ Trauma ❑ Motor Vehicle Accident ❑ Sports Injury ❑ Work Related Injury ❑ Fall ❑ Unknown

Describe the event:

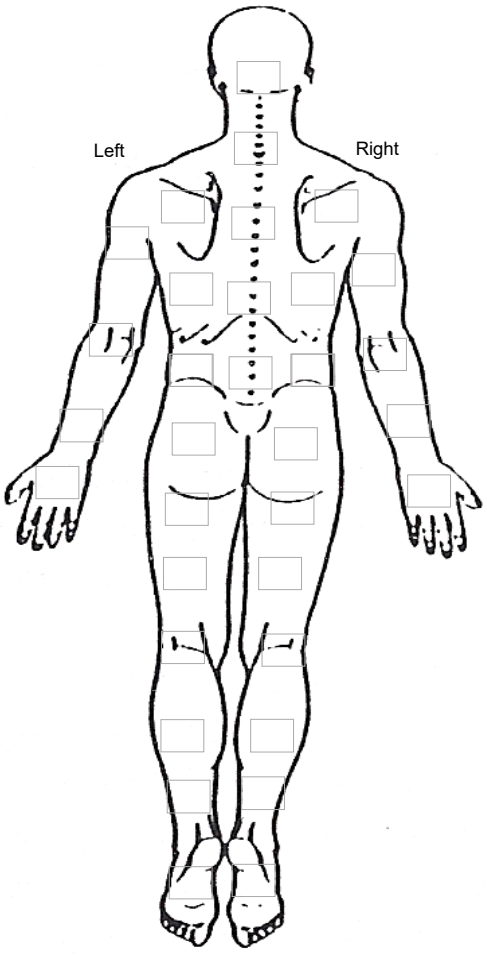
Have you experienced this condition prior to this episode? ❑ No ❑ Yes *(if yes, when)* _____

Length of time with current symptoms:

❑ 0 – 6 weeks ❑ 6 – 12 weeks ❑ 3 – 9 months ❑ 9 – 18 months ❑ > 18 months

Please Mark the area on the diagram that corresponds to where you feel the pain. Include all affected areas:

XXX = Pain



Pain in arm(s) compared to pain in neck

❑ Worse than

❑ Same as

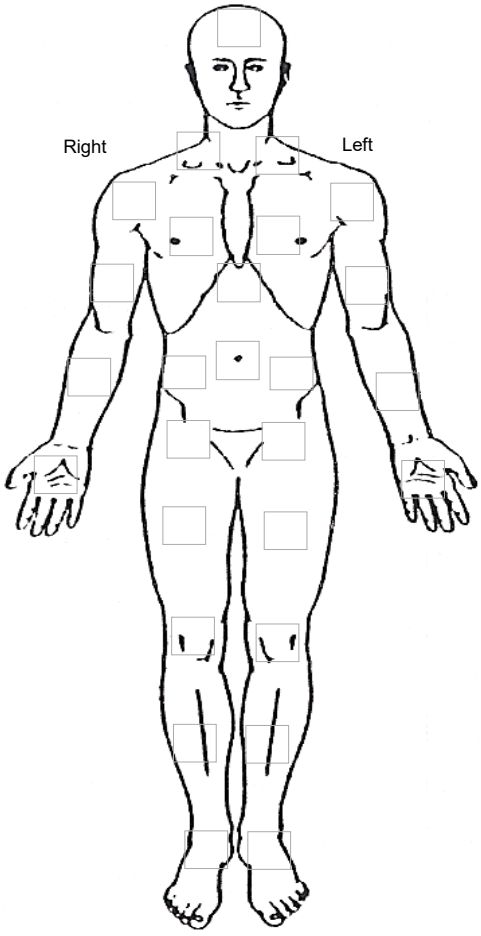
❑ Less than

Pain in leg(s) compared to pain in back

❑ Worse than

❑ Same as

❑ Less than



Please describe the interval of your pain/symptoms by checking the appropriate box.

❑ Constant (pain/symptom is present all the time)

❑ Frequent (pain/symptom is present most of the time)

❑ Occasional (pain/symptom is present sometimes)

❑ Intermittent (pain/symptom comes and goes)

Patient Name:

How would you describe the pain/symptom(s) you experience the most?

❑ Achy/Dull ❑ Sharp/Stabbing ❑ Numbness ❑ Burning

❑ Stiffness ❑ Pins & Needles ❑ Other _____

Please rate your **current pain** on a scale from 0 to 10 (0 = No pain, 10 = Unbearable pain): _____ Enter Number here / 10

Since the start of this condition, it is: ❑ Getting Better ❑ Getting Worse ❑ Unchanged

What aggravates your condition? ❑ Standing _____ minutes ❑ Walking _____ minutes ❑ Sitting _____ minutes ❑ Lifting _____ lbs

❑ Other _____

What relieves your condition? ❑ Rest ❑ Heat ❑ Ice ❑ Exercise _____ ❑ Medication _____

❑ Other _____

Do you experience loss of control of your bowel or bladder function: ❑ No ❑ Yes

Do you experience pain at night when sleeping? ❑ No ❑ Yes, Have you experienced recent rapid weight loss? ❑ No ❑ Yes

Have you had surgery or procedure for **this condition**? ❑ No ❑ Yes *(if yes, please list the surgery/procedure(s) below)*

Surgery #1 _____ Date: DD / MM / YY _____ Surgeon:_____

Surgery #2 _____ Date: DD / MM / YY _____ Surgeon:_____

Have you been hospitalised for **this condition**? ❑ No ❑ Yes *(if yes, which hospital)* _____

Previous Treatments for this Condition: *(Check all treatments previously received for this condition)*

❑ Physiotherapy ❑ Chiropractic ❑ Massage ❑ Acupuncture ❑ Naturopathic ❑ Other _____

❑ Spine injections Type of injection(s): ❑ Steriod ❑ Anesthetic *(lidocaine)* ❑ Trigger point ❑ Other _____

Describe the result/reaction you had to the injection(s)/or treatment(s):_____

What diagnotic test(s) have you had for this condition:

❑ X-ray ❑ MRI ❑ CT Scan ❑ Ultrasound ❑ Bone Scan ❑ Other _____

Do you have a copy of the images on film or CD: ❑ No ❑ Yes *(if yes, present the images to the physician at the time of the assessment)*

Medication & Allergies

Please check medications you are currently taking:

❑ Tylenol ❑ Tylenol #3 ❑ Ibuprofen ❑ Advil ❑ Aleve ❑ Roboxacet ❑ Arthrotec ❑ Gabapentin/Lyrica _____mg

❑ Tramacet/Tramadol _____mg ❑ Naproxen _____mg ❑ Morphine _____mg ❑ Percocets _____mg ❑ Oxycontin _____mg

Please list all **other** medications

Allergies to medication: ❑ None ❑ Yes *(if yes, please list all):* _____

Latex Allergy Screening: Have you ever had a reaction such as; swelling, itching or difficulty breathing when exposed to latex, rubber materials like gloves, condoms or balloons. ❑ No ❑ Yes *(if yes, please describe reaction)*: _____

Past Medical History

Please list all medical conditions:

List all **other** previous surgery(s)*:* _____

Please list any relavent family history:

Social & Occupational History

Current Work & Activity Status: Occupation**:** _____

❑ Working ❑ On disability or leave due to condition ❑ Not working due to condiiton

❑ Not Working ❑ Able to do all activities despite condition ❑ Difficulty doing activities due to condition

Social History: *(Check any of the activities below that you are currently involved with)*

Do you Smoke or Chew Tobacco? ❑ No ❑ Yes *if yes, how many packs per day?* _____

Do you drink alcohol? ❑ No ❑ Yes *if yes, how often?* _____ *x per week or* _____ *x per month*

Do you use any street/recreational drugs? ❑ No ❑ Yes *if yes, please specify* _____

In general would you say your health is: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Comments:

CALEO HEALTH
Riley Park Village
200 – 1402 8th Avenue N.W.
Calgary, AB T2N 1B9
Ph: 403-241-3529
Fax: 403-452-0995
http://www.caleohealth.ca

SPINE ASSESSMENT INFORMATION

CALEO HEALTH SPINE: A partnership of Spine Surgeons associated with the University of Calgary. The team also consists of; Spine Focused Physicians, Physiatrists & other Allied Health Professionals.

We are a multidisciplinary patient focused centre with a structured triage approach with emphasis on diagnostic and treatment recommendations. The triage process is designed to provide: single-site management of your condition(s), coordinate investigations and optimize care processes. We offer a continuum of care where patients are referred to the most appropriate healthcare provider for management and treatment.

Why: To address a critical delay in access to specialist and multidisciplinary assessment and management of patients with spinal diseases and injuries.

What: You have been referred for assessment with our triage team: Spine Focused Physician, Physiotherapist/Chiropractor and rehabilitation coordinators. You will not be seeing a surgeon on your first visit.

PATIENTS ASSESSED AND DEEMED APPROPRIATE FOR SURGICAL INTERVENTION WILL RECEIVE A FORMAL CONSULTATION WITH A SPINE SURGEON. *Please be aware that a referral to a surgeon does not mean you need surgery or will be offered surgery.*

Approximately 44 % of the patients assessed at Caleo Health meet the criteria of a surgical candidate. The current average wait time is approximately 18-24 Months for routine consultation with a spine surgeon

NONSURGICAL PATIENTS WILL BE PROVIDED WITH APPROPRIATE TREATMENT RECOMMENDATION(S), REFERRAL AND FOLLOW UP.

The initial visit to Caleo Health focuses on evaluating your most critical area of complaint. The goal is to provide you and your physician; the most responsible diagnosis, subsequent care pathway recommendation(s) and/or referral(s) necessary for the treatment of your spinal condition.

As part of the assessment and management process a referral to one (1) or more of the following may be necessary:

1. Investigational Studies: such as, MRI, X-Ray, CT, etc.
2. Electro-diagnostics: such as EMG or NCS studies.
3. Pain Clinic: evaluation & intervention(s) (facet: injections, nerve blocks, etc.)
4. Allied Health Professional: such as specific and specialized physiotherapy and/or Chiropractic.
5. Medical Specialist: as deemed necessary by the assessment team
6. Surgical Specialist: further consultation with a surgeon to discuss surgical options.

FEE: The fee to the patient for the initial appointment. May be submitted to your Extended Health benefits Plan for consideration of reimbursement. Invoices for non-insured services will be provided. It is the responsibility of the patient to submit invoices and discuss reimbursements with their Extended Healthcare Provider.

Follow-up visits with the spine physician are covered by most Provincial Health Plans (i.e. Alberta Health) for patients with a valid Provincial Health Number.