

Post operative Check

Name: _____ **Post-op** _____ **mos.**

Date ____/____/____

Surgery date _____

Surgery performed: Cervical/Thoracic/Lumbar
Laminectomy
Fusion

Back pain improved/static/worsened

Neurologic recovery improved/same/worse

Sensory deficits: none/_____

Motor deficits: none/_____

Pain meds: none/weaning/unchanged pills/day _____

Activity, walking ____ minutes

Complications: none/_____

Physical exam:

Wound: Dry/drainage swollen/tender/red

Sensation: Intact/ numb where

| | | |
|-------|----------------|----------------|
| Motor | Biceps | quadricep |
| | Wrist extensor | dorsiflexion |
| | Triceps | plantarflexion |
| | Grip | peroneals |
| | Opposition | |

Pain Level: ____/10

Recovery: Fast/slow/as expected/problems _____

X-rays C/T/L alignment: good/scoliosis/spondylolysthesis/unstable/unchanged

Fusion: progressing/solid/scant/psuedoarthrosis

Instrumentation: good position/loose/out of position

- Plan:**
1. PT: Home/outpatient/Hold
 2. Brace: Full time/ Part time/ Wean/ Discontinue
 3. Perscriptions written: none/_____
 4. Follow-up appointment _____ wks/mos
 5. X-rays 2 Views C/ T/ L spine

Did surgery help you? Yes/no

Are you returning to usual activities? Yes/no/not yet

Are you healed? Yes/no/not yet

Would you do surgery again? Yes/no