

SPINE PATIENT QUESTIONNAIRE

Please answer the following questions with the most accurate response possible. If some of the questions are unclear or do not apply, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your visit, and you can clarify your answers at that time. Thank you.

Name: _____ Date: _____

Age: _____ Male Female Occupation: _____

Referred by: _____

Family / Primary MD (location): _____

- A.** 1. Location of initial pain (*check all that apply*): Neck pain Arm pain Back pain Leg Pain
 2. How long has the pain (or your problem) been present? _____
 3. What started the pain/problem? _____

B. For patients with NECK OR ARM PAIN ONLY: (for back pain, skip this section and go to “C”)

1. Does pain go into arms? _____ % Left _____ % Right
2. Raising the arm: improves the pain worsens the pain no change
3. Moving the neck: improves the pain worsens the pain no change
4. There is: Weakness in the arms or hands NO weakness in the arms or hands
5. There is: Numbness in the arms or hands NO numbness in the arms or hands
6. Do you have difficulty picking up small objects or buttoning your buttons? YES NO
7. Do you have problems with balance, or trip frequently? YES NO

END OF NECK OR ARM PAIN QUESTIONS, PLEASE GO TO “D”

C. For patients with BACK PAIN, LEG PAIN, NUMBNESS OR WEAKNESS.

1. What percent of your pain is back pain (from mid-back to buttocks)? _____ %
2. What percent of your pain goes down your leg? Left _____ % Right _____ %
3. Do you have pain that “shoots” or goes below your knees? YES NO
4. There is weakness of my: _____
5. There is numbness of my: _____
6. The worst position for my pain is: Sitting Standing Walking
7. How many minutes can you stand in one place without pain? _____ minutes
8. How many blocks can you walk without pain? _____ blocks
9. Lying down: Eases my pain Makes my pain worse No effect

D. ALL PATIENTS should answer the following:

1. There is: NO loss of bowel or bladder control Loss of control since _____
2. I have: NOT missed any work because of this problem Missed work (how much?): _____
 Have been on light duty (since?): _____

3. Previous doctors seen for this problem:

<i>Doctor</i>	<i>Specialty</i>	<i>City</i>	<i>Treatments</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Diagnostic tests done to evaluate this problem:

	<i>City</i>	<i>Date</i>
<input type="checkbox"/> X-ray:	_____	_____
<input type="checkbox"/> Cat Scan:	_____	_____
<input type="checkbox"/> Myelogram:	_____	_____
<input type="checkbox"/> MRI:	_____	_____
<input type="checkbox"/> EMG:	_____	_____
<input type="checkbox"/> Bone Scan:	_____	_____

5. Treatments so far include:

- Physical therapy: _____ visits
- Exercise program - how long? _____
- Chiropractic Acupuncture
- Tens unit Braces
- Anti-inflammatory medications (e.g., Motrin or Naproxen)
- Narcotic medications (e.g., Tylenol #3, Vicoden, Darvocet)
- Epidural injections: _____ times. How long did they relieve the pain for? _____

E. MEDICATIONS YOU TAKE FOR ALL HEALTH ISSUES: (list dose and frequency):

None

<i>Medication</i>	<i>Dosage</i>
_____	_____
_____	_____
_____	_____

F. MEDICATIONS YOU HAVE TRIED FOR YOUR SPINE PROBLEM (list dose and frequency):

<i>Medication</i>	<i>Dosage</i>
_____	_____
_____	_____
_____	_____

G. MEDICATION ALLERGIES: None

<i>Medication</i>	<i>Reaction</i>
_____	<input type="checkbox"/> rash <input type="checkbox"/> upset stomach <input type="checkbox"/> wheezing or shock <input type="checkbox"/> other: _____
_____	<input type="checkbox"/> rash <input type="checkbox"/> upset stomach <input type="checkbox"/> wheezing or shock <input type="checkbox"/> other: _____
_____	<input type="checkbox"/> rash <input type="checkbox"/> upset stomach <input type="checkbox"/> wheezing or shock <input type="checkbox"/> other: _____

Iodine Allergy: NO YES, describe reaction _____

H. YOUR MEDICAL HISTORY (check all that apply): None apply

- | | | |
|-------------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Gout | <input type="checkbox"/> AIDS | <input type="checkbox"/> Serious injury: _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> Other: _____ |

I. SURGICAL HISTORY (including spine):

<i>Operation</i>	<i>Surgeon/City</i>	<i>Date</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

J. INJURY HISTORY:

1. Do you have a prior history of back or neck problems? _____
2. Any prior industrial or Workers' Compensation claims? YES NO Explain: _____

K. SOCIAL HISTORY & HABITS:

1. Work status: Homemaker Working Retired Disabled On leave
2. Date last worked: _____
3. Marital status: Single Married Divorced Widowed Co-Habiting
4. I live: Alone With: _____
5. Tobacco: Never Cigar Chew Pipe Cigarettes ___ packs/day for ___ years Quit, when? _____
6. Alcohol: Never or rare Social Frequently (more than twice a week) Alcoholic Recovering
7. Illicit/Street Drug usage: Never In the past Currently IV drugs
8. Because of this problem, do you have or plan to have: Law suit Workman's Comp Claim Unsure None

L. FAMILY HISTORY (list any illnesses that “run” in your family):

M. REVIEW OF SYSTEMS (check all that apply): None apply

- | | | |
|------------------------------------------------|--------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Reading glasses | <input type="checkbox"/> Toothache | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Gum trouble | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Frequent rash |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hot or cold spells |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent belching | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Morning cough | <input type="checkbox"/> Frequent constipation | Women Only: |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Heart or chest pains | <input type="checkbox"/> Burning on urination | <input type="checkbox"/> Frequent spotting |
| <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Is your primary care doctor aware of the above check problems? YES NO

N. Approximate height: _____ **Approximately weight:** _____

O. Indicate the location and description of your pain by placing the appropriate letter symbols on the body diagram below:

TYPE OF PAIN	SYMBOL
Aching	AAAA
Burning	BBBB
Numbness.....	NNNN
Pins & Needles.....	PPPP
Stabbing	SSSS

