

## 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 BACKPAIN, LEGPAIN, 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>
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4. Diagnostic tests done to evaluate this problem:

<i>City</i>	<i>Date</i>
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- X-ray: \_\_\_\_\_  
 Cat Scan: \_\_\_\_\_  
 Myelogram: \_\_\_\_\_  
 MRI: \_\_\_\_\_  
 EMG: \_\_\_\_\_  
 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

*Medication*

*Dosage*

_____	_____
_____	_____
_____	_____

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

*Medication*

*Dosage*

_____	_____
_____	_____
_____	_____

**G. MEDICATION ALLERGIES:**  None

<i>Medication</i>	<i>Reaction</i>			
_____	<input type="checkbox"/> rash	<input type="checkbox"/> upsetstomach	<input type="checkbox"/> wheezing orshock	<input type="checkbox"/> other: _____
_____	<input type="checkbox"/> rash	<input type="checkbox"/> upsetstomach	<input type="checkbox"/> wheezing orshock	<input type="checkbox"/> other: _____
_____	<input type="checkbox"/> rash	<input type="checkbox"/> upsetstomach	<input type="checkbox"/> wheezing orshock	<input type="checkbox"/> other: _____

**Iodine Allergy:**  NO  YES, describe reaction

\_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heartattack            | <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"/> Thyroidtrouble        |
| <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**

- Do you have a prior history of back or neck problems? \_\_\_\_\_
- Any prior industrial or Workers' Compensation claims?  Yes  No Explain:  
\_\_\_\_\_  
\_\_\_\_\_

**K. SOCIAL HISTORY & HABITS:**

- Workstatus:  Homemaker  Working  Retired  Disabled  On leave
- Date last worked: \_\_\_\_\_
- Marital status:  Single  Married  Divorced  Widowed  Co-Habiting
- I live:  Alone  With: \_\_\_\_\_
- Tobacco:  Neve  Cigar  Chew  Pipe  Cigarettes \_\_\_pack/day for \_\_\_years  Quit, when? \_\_\_\_\_
- Alcohol:  Never or rare  Social  Frequently (more than twice a week)  Alcoholic  Recovering
- Illicit/Street Drug usage:  Never  In the past  Currently  IV Drugs
- 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):**

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**M. REVIEW OF SYSTEMS (check all that apply):**

None apply

- Reading glasses
- Change of vision
- Loss of hearing
- Ear pain
- Hoarseness
- Nose bleeds
- Difficulty swallowing
- Morning cough
- Shortness of breath
- Fever or chills
- Heart or chest pains
- Abnormal heartbeat
- Swollen ankles

- Toothache
- Gum trouble
- Nausea or vomiting
- Stomach pain
- Ulcers
- Frequent belching
- Frequent diarrhea
- Frequent constipation
- Hemorrhoids
- Frequent urination
- Burning on urination
- Difficulty starting urination
- Other: \_\_\_\_\_

- Frequent Headaches
- Blackouts
- Seizures
- Frequent rash
- Hot or cold spells
- Recent weight change
- Nervous exhaustion

**Women Only:**

- Irregular periods
- Vaginal discharge
- Frequent spotting

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

