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.

Na	me:	Date:					
Ag	e: _	☐ Male ☐ Female Occupation:					
Ref	ferre	ed by:					
 Far	nily	/ Primary MD (location):					
— A.	2.	Location of initial pain (check all that apply):					
В.	Fo	r patients with NECK ORARM 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 u worsens the pain u no change					
	3.	B. 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?					
		END OF NECK OR ARM PAIN QUESTIONS, PLEASE GO TO "D"					
с.	Fo	rpatients 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?					
	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					

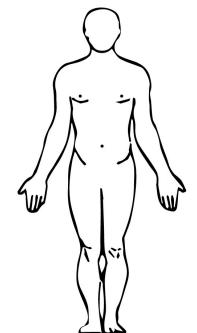
	NO loss of bowel or blade OT missed any work becar		☐ Loss of control si☐ Missed work (ho	nce: w much?):
3. Previous do	ctors seen for this problen			
	Doctor	Specialty	City	Treatments
4. Diagnostic	ests done to evaluate this			
-	-	City		Date
	🕽 X-ray:			
Ę	〕 EMG:			
Ţ	☐ Bone Scan:			
5. Treatment	sso far include:			
	Physical therapy:	visits		
	Exercise program - hov			
	<u> </u>	Acupuncture		
		∃ Braces		
	☐ Anti-inflammatory med		•	
	Narcotic medications (e			
	Epidural injections:	times. Hov	v long did they relieve	the pain for?
MEDICATIONS Y	OU TAKE FOR <u>ALL</u> HEALT	H ISSUES: (list dose	and frequency):	☐ None
Me	edication			Dosage
	OU HAVE TRIED FOR YOU	R SPINE PROBLEM (I	ist dose andfrequen	cy):
M	edication			Dosage

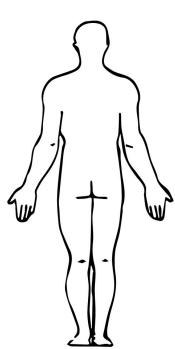
	EDICATION ALLERGIES:	☐ None				
Me	edication	Reaction				
		🗖 rash	upsetstomach	$oldsymbol{\square}$ wheezing or shock	☐ other:	
		🗖 rash	upsetstomach	$oldsymbol{\square}$ wheezing or shock	☐ other:	
		🗖 rash	upsetstomach	$oldsymbol{\square}$ wheezing or shock	☐ other:	
Iod	ine Allergy: 🔲 NO	☐ YES, describ	e reaction			
. YOL	JR MEDICAL HISTORY (c	heck all that appl	 y): □ No	one apply		
	☐ Heartatta	ack	Mental Illness	Stomach ulcers		
	☐ Heart fai	lure	☐ Kidney stones	Liver trouble		
	☐ High Blood Pressure ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Ankylosing Spondylitis		Kidney failure	☐ Hepatitis		
			☐ Cancer	☐ Thyroidtrouble☐ Bleeding disorder		
			Alcoholism			
			Lung disease	☐ Anemia		
	☐ Gout	<u> </u>	☐ AIDS	Serious injury:		
	☐ Osteopor	osis	☐ Tuberculosis	☐ Other:		
	☐ Diabetes		Asthma	☐ Other:		
	☐ Stroke		Blood clot in leg	☐ Other:		
INJUI	RY HISTORY					
1.	Do you have a prior his	tory of back or necl	c problems?			
	Do you have a prior his	·	•	□ No Explain:		
	Any prior industrial or	Workers' Comper	c problems? Yes	•		
	Any prior industrial or	Workers' Comper	nsation claims? 🗖 Yes	•		
2.	Any prior industrial or	Workers' Comper	nsation claims? 🗖 Yes	•		
2. . soc	Any prior industrial or	Workers' Comper	nsation claims? 🗖 Yes			
2. 7. soc 1.	Any prior industrial or CIAL HISTORY & HABITS: Work status:	Workers' Comper	g Retired Disable	d □ On leave		
2. SOC 1. 2.	Any prior industrial or CIAL HISTORY & HABITS: Work status: Home	Workers' Comper	g Retired Disable	d 🖵 On leave		
2. 500 1. 2. 3.	Any prior industrial or CIAL HISTORY & HABITS: Work status: Home Date last worked: Sin	Workers' Comperemaker	g Retired Disabled	d □ On leave wed □ Co-Habiting		
2. 500 1. 2. 3. 4.	Any prior industrial or CIAL HISTORY & HABITS: Work status: Home Date last worked: Sin Marital status: Sin	Workers' Comperemaker	g Retired Disable	d □ On leave wed □ Co-Habiting		
2. SOC 1. 2. 3. 4. 5.	Any prior industrial or CIAL HISTORY & HABITS: Work status: Home Date last worked: Marital status: Sii Ilive: Alone Wi Tobacco: Neve	workers' Comperemaker	g Retired Disabled Divorced Wido	d	Quit, when?	
2. soc 1. 2. 3. 4. 5. 6.	Any prior industrial or CIAL HISTORY & HABITS: Work status: Home Date last worked: Sin Ilive: Alone Wi Tobacco: Neve Alcohol: Never of	workers' Comperemaker	g Retired Disable	d On leave wed Co-Habiting pack/day foryears	Quit, when?	

VIEW OF SYSTEMS (check all tha	t apply):	
☐ Reading glasses	☐ Toothache	☐ Frequent Headaches
☐ Change of vision	☐ Gum trouble	☐ Blackouts
Loss of hearing	Nausea or vomiting	☐ Seizures
🗖 Ear pain	Stomach pain	Frequent rash
☐ Hoarseness	☐ Ulcers	☐ Hot or cold spells
☐ Nose bleeds	Frequent belching	☐ Recent weight change
☐ Difficulty swallowing	Frequent diarrhea	Nervous exhaustion
☐ Morning cough	Frequent constipation	Women Only:
☐ Shortness of breath	Hemorrhoids	Irregular periods
Fever or chills	Frequent urination	Vaginal discharge
☐ Heart or chest pains	Burning on urination	☐ Frequent spotting
☐ Abnormal heartbeat	Difficulty starting urination	Other:
☐ Swollen ankles	Other:	

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





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