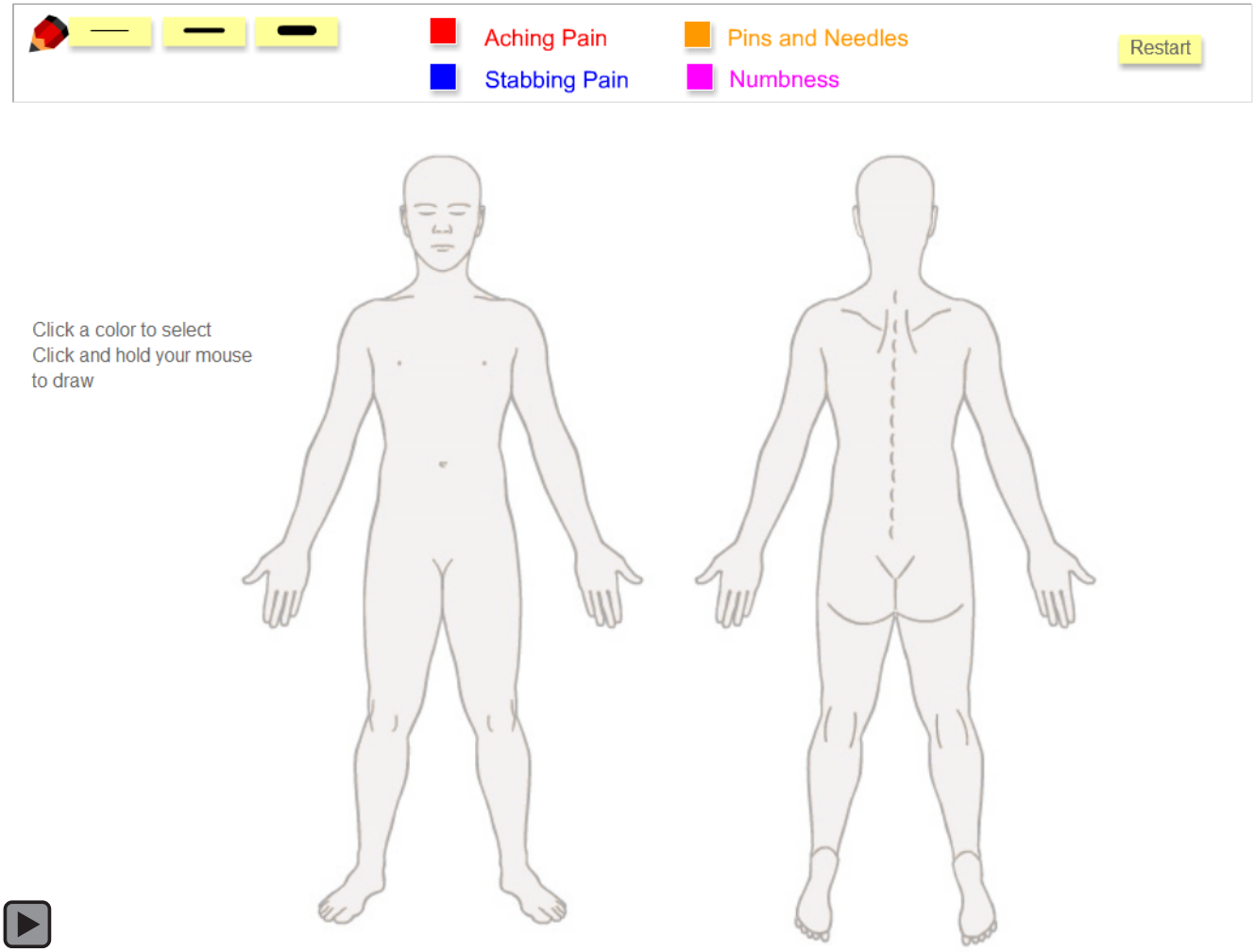
Spine Patient Questionnaire

Name: _____ Age: _____ Date: _____

Right or Left Handed? Right ◯ Left ◯ Height _____ (feet-inches) Weight _____ (pounds)

On the body diagrams use the appropriate pencil to mark where you feel the following sensations:



Please indicate (with an X) how severe your pain is now.

No Pain ◯----◯----◯----◯----◯----◯----◯----◯----◯----◯----◯ Worst pain

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

1. When did your present pain start (approximately what date)? _____

2. Is your pain due to a work-related injury? ◯ no ◯ yes if yes, when? _____

3. Is your pain due to an auto accident injury? ◯ no ◯ yes if yes, when? _____

4. Have you had similar pains in the past? ◯ no ◯ yes
   If yes, when? _____

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5. How did your pain start? (Please check (x) all that apply to you.) ○ *No apparent cause*
○ Suddenly ○ Gradually ○ Bending ○ Lifting ○ Twisting ○ Pushing ○ Pulling ○ After a fall

6. Please describe how your pain started: _____
_____
_____

7. Have you been hospitalized or seen in the Emergency Room for your pain? ○ no ○ yes
If yes, when/where? _____

8. What activities make your pain worse? (Please check (x) all that apply to you.) ☐ *None*
☐ Lying ☐ Standing ☐ Exercise (during) ☐ Bending Forward ☐ Twisting
☐ Sitting ☐ Walking ☐ Exercise (after) ☐ Bending Backward ☐ Coughing/Sneezing
☐ Early Morning ☐ End of day ☐ Other_____

9. What reduces your pain? (Please check (x) all that apply to you.) ☐ *None*
☐ Lying ☐ Standing ☐ Bending Forward ☐ Exercise ☐ Heat/Cold ☐ Physical Therapy
☐ Sitting ☐ Walking ☐ Bending Backward ☐ Pain Pills ☐ Massage ☐ Chiropractic Treatment
☐ Rest ☐ Other_____

10. What types of treatment have you had? (Please check (x) all that apply to you.) ☐ *None*
☐ Physical Therapy ☐ Epidural Steroid Injection(s) ☐ Trigger Point Injections
☐ Facet Injection(s) ☐ Pool Therapy ☐ Chiropractic Treatment
☐ Other_____

11. Review of systems
Please check (x) all problems that apply to you. ☐ *None*
☐ Numbness/tingling of arms or legs ☐ Weakness of arms or legs ☐ Night pain/difficulty sleeping
☐ Bladder/bowel ☐ Sexual difficulties ☐ Chest pain/short of breath
☐ Psychiatric/emotional ☐ Endocrine/hormonal ☐ Fever, chills, or weight loss
☐ Difficulty w/hands or buttons ☐ Blurry vision/headaches ☐ Skin rashes
☐ Other difficulties-what kind? _____

12. Have you had any of the following diagnostic studies?	No	Yes	Date
Diagnostic X-rays	○	○	_____
CT (computed tomography) scan	○	○	_____
MRI (magnetic resonance image)	○	○	_____
Myelogram	○	○	_____
Discogram	○	○	_____
EMG (electromyogram)/NCV (nerve conduction velocity)	○	○	_____
Other	○	○	_____

13. Have you had surgery for this pain or similar pain? ○ no ○ yes
If yes, describe what type of surgery you had, when and where performed, and the name of the surgeon. _____

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Past Medical History

Please check (x) the box next to any illnesses or problems that apply to you. ☐ *None*

☐ Heart Trouble	☐ Kidney disease	☐ High Blood Pressure
☐ Liver disease/hepatitis	☐ Diabetes	☐ Ulcers/Reflux
☐ Stroke	☐ Skin rashes/lesions	☐ Epilepsy/seizures
☐ Bleeding/bruising problems	☐ Asthma/emphysema	☐ Sickle cell anemia
☐ Thyroid	☐ Cancer	☐ Arthritis-what type?_____

☐ Other medical problems-what kind? _____

Past Surgical History

Please check (x) the box next to any surgical procedures that you have had. ☐ *None*

☐ Lumbar spine/low back	☐ Lung	☐ Stomach	☐ Gall Bladder
☐ Cervical spine/neck	☐ Heart	☐ Appendix	☐ Uterus/Ovaries/Gyn
☐ Thyroid	☐ Liver	☐ Bowel/Hemorrhoid	☐ Prostate
☐ Breast	☐ Kidney	☐ Hernia	☐ Extremities/arms or legs
☐ Tonsils	☐ Cardiac stent		

☐ Other surgeries-what kind? _____

Allergies

Please check (x) the box next to any allergies that apply to you. ☐ *None Known*

☐ Penicillin ☐ Sulfa ☐ Iodine

☐ Other antibiotics or medications, foods, or dyes: _____

Do you have difficulty taking anti-inflammatory medications? ◯ no ◯ yes ◯ don't know

Medications Currently Taking

Please list name of drug, dosage, and how often taken. ☐ *None*

_____ _____

_____ _____

_____ _____

_____ _____

Family History

Please check (x) the box next to any disease diagnosed in your blood relatives.

☐ Cancer	☐ Diabetes	☐ Bleeding problems
☐ Heart Disease	☐ Sickle cell anemia	☐ Other: _____

Social History

Please check (x) all that apply to you.

Tobacco use: ◯ no ◯ yes if yes, packs per day _____ and years of use _____

Alcohol use: ◯ no ◯ yes if yes, amount per week _____

Non-prescribed medications or recreational drugs: None _____

Work Status: Are you ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired?

What is your occupation? _____

Is this the same occupation you had before your injury? ☐ yes ☐ no ☐ n/a

If no, what was your previous occupation? _____

Are you still working? ◯ yes ◯ no ◯ n/a If no, what was last day on the job? _____

If working, are you at ☐ full duty or ☐ light duty?

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