SPINE NEW PATIENT QUESTIONAIRE

Rev 12/06/10

Name:______________________________ Today's Date:_________________

Male ○ Female ○ Date of Birth:_________________

Height:_________ Weight:__________ Age today:___________________

Referring Doctor:______________________ Primary Doctor:_______________

What hurts you? ____

____

How long has it hurt?____

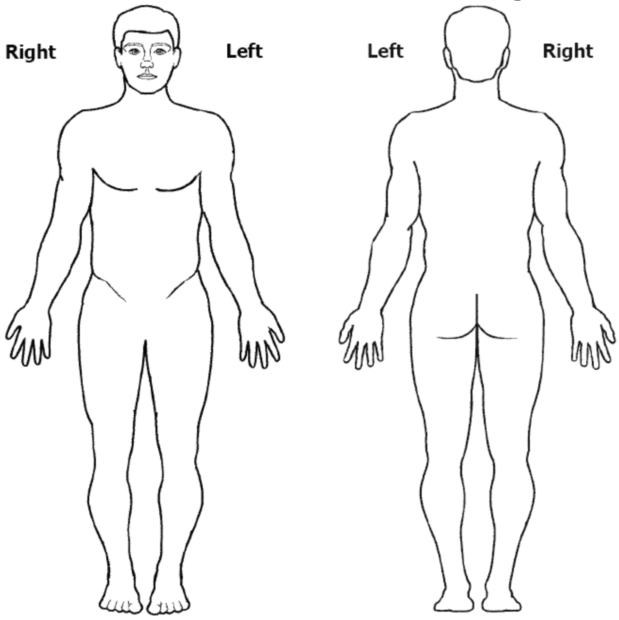
♦♦

Please complete all information. You may select more than one answer per question. Feel free to add additional information in the margins. *Thank you for taking your time to fill this out completely.*

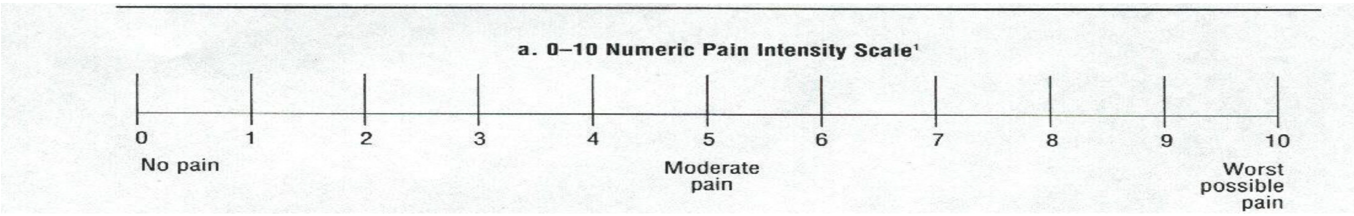
♦♦

Pain Drawing: Mark these drawings using the symbols that best describe your pain quality:

Numbness:+++ Pain: >>> Burning: ----------



The following lines represent pain of increasing intensity from "no pain" to "very severe pain." Please mark on the line the level of your pain right now:



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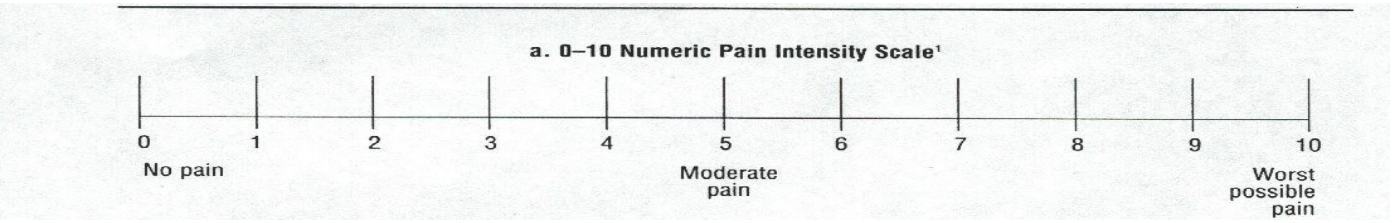
Your Pain at its worst:



What happened to cause your injury or pain? **Date of Injury/ When pain started:_____**

[ ] Spontaneous Onset [ ] Job Related / Workers compensation [ ] Sports or Recreation
[ ] Motor Vehicle Accident - No Lawsuit [ ] Motor Vehicle Accident - Lawsuit [ ] Fall

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What pain brings you here today?

[ ] Neck Pain
[ ] Upper Back Pain
[ ] Lower Back Pain
[ ] Right Leg Pain
[ ] Left Leg Pain
[ ] Pain in Both Legs
[ ] Right Arm Pain
[ ] Left Arm Pain
[ ] Pain in Both Arms
[ ] Scoliosis
[ ] Other – Specify

If you have neck pain, what percent is neck pain and what percent is arm pain?

_____% Neck _____% Arm

If you have back pain, what percent is back pain and what percent is leg pain?

_____% Back _____% Leg

Did the pain start immediately or was there a delayed onset?

[ ] Immediate
[ ] Delayed 1-4 days
[ ] Delayed 1-2 weeks
[ ] Delayed 2-4 weeks
[ ] Delayed 4-8 weeks

Since the pain/condition began has it:

[ ] Improved
[ ] Not changed
[ ] Continued to come and go
[ ] Worsened

Since the pain/condition began has it:

[ ] Improved
[ ] Not changed
[ ] Continued to come and go
[ ] Worsened

Do you participate in sports or athletics?

[ ] Regularly 3x/week
[ ] Regularly 2x/week
[ ] Regularly 1x/week
[ ] Irregularly
[ ] None
[ ] Medical Problems Prevent

What aggravates the pain?

[ ] Walking
[ ] Standing
[ ] Sitting
[ ] Lying down
[ ] Bending Forward
[ ] Bending Backwards
[ ] Twisting
[ ] Lifting
[ ] Nothing in particular

What makes the pain better?

[ ] Sitting
[ ] Lying down
[ ] Walking
[ ] Standing
[ ] Leaning Forward or a Shopping Cart
[ ] Nothing in particular

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What relieves your pain? Check all that apply:

[ ] Nothing
[ ] Physical therapy
[ ] Active exercise
[ ] TENS unit
[ ] Heat
[ ] Cold
[ ] Manipulation
[ ] Other – Specify:

[ ] Spinal injections
[ ] Epidural [ ] Facet Injections [ ] Unknown
[ ] Surgery
[ ] Pain psychology
[ ] Holistic or alternative treatments
[ ] Chiropractor
[ ] Medication

Do you have any problems with bowel, bladder, or sexual functions?

[ ] None
[ ] No problems except for occasional constipation
[ ] Difficulty controlling bladder functions
[ ] History of urinary tract infections
[ ] Sexual problems secondary to pain
[ ] Physical problems with sexual function other than pain
[ ] Other - Specify

Do you have any difficulty walking?

[ ] No
[ ] Yes, can walk less than a mile
[ ] Yes, can walk only 1-2 blocks
[ ] Yes, can walk unlimited distance
[ ] Yes, non-ambulatory

Are you right or left handed?

[ ] Right handed
[ ] Left handed
[ ] Ambidextrous

Current Medications–

What medications are you currently taking, and for what medical problem? Attach list or use back if necessary

Name:	***Dosage:***	***Frequency:***	***Notes:***

Allergies:

Medication	**Reaction**	**Medication**	**Reaction**

Please provide name and address of your current Pharmacy: (You must complete this question)

_____

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Medical History: (please check any/ all of the following that apply)

- ☐ Aids/HIV
- ☐ Asthma
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes (Type 1 or 2)
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Gout
- ☐ Heart Attack
- ☐ Murmur
- ☐ Hepatitis A/B/or C
- ☐ High Blood Pressure
- ☐ Lung Disease
- ☐ Malaria
- ☐ Mitral Valve Prolapse
- ☐ Musculoskeletal Disorder
- ☐ Non-Healing Wounds
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Stroke/CVA
- ☐ Swelling in Legs/Feet
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Phlebitis

SURGICAL HISTORY

What surgery have you had **(including spine or back surgery)?** Attach list or use back if necessary

Date:	Place:	Surgeon:	Procedure:
________	__________	__________________	____
________	__________	__________________	____
________	__________	__________________	____

Have you had any of the following complications of surgery?

[ ] Bleeding
[ ] Infection
[ ] Poor Wound Healing
[ ] Nonunion of fusion/ fracture
[ ] Blood clot in legs
[ ] Other – Specify

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WORK HISTORY

Is your injury job related?
[ ] Yes [ ] No
If Yes: Date of Injury_________________

Have you ever filed a prior work comp injury?
[ ] Yes [ ] No
If Yes, Date:_____________________

Are you currently receiving or seeking disability for this condition? [ ] Yes [ ] No

What is your current work status?
[ ] Regular Employment - No Restrictions
[ ] Full-Time with Restrictions
[ ] Homemaker
[ ] Part-Time by Choice
[ ] Part-Time for Medical Reasons
[ ] Retired by Choice
[ ] Retired by Medical Reasons
[ ] Unemployed - Looking for work without restrictions
[ ] Unemployed - Looking for light duty
[ ] Unemployed
[ ] Student
[ ] Other – Specify

Who is the primary treating physician for your work comp injury?
____

Have you returned to work?
[ ] Yes [ ] No If Yes, __________________________

Do you have an attorney?
[ ] Yes [ ] No If Yes, __________________________

What is your occupation?
____

Who is your current employer:
____

Have you attempted to return to work since the onset of your pain?
[ ] Yes – When did you attempt this return?
[ ] No
[ ] This does not apply to me.

When did you last work?____________________

Physical activities at work (check all that apply)
[ ] Sitting [ ] Standing [ ] Repetitive lifting [ ]Heavy lifting [ ] Phone use
[ ] Computer use [ ] Heavy equipment operation [ ] Driving

♦♦

Please use this space to explain any detail that the doctor needs to know:

____

____

____

____

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SOCIAL HISTORY

Are you:
[ ] married
[ ] partner
[ ] single
[ ] divorced
[ ] widow/widower
[ ] separated

With whom do you live?
[ ] living with spouse
[ ] living alone
[ ] living with children
[ ] living with parents
[ ] living in an assisted living community
[ ] other

Do you have children?
[ ] Yes [ ] No Yes:________________________

Do you drink alcoholic beverages?
[ ] Yes [ ] No
Amount:___________________________________

What is the highest grade you completed or degree you received?________________________

Do you smoke cigarettes?
[ ] No - I have never smoked
[ ] No – I quit ____ months / years ago
[ ] Yes _____ packs per day
[ ] Currently chew tobacco / snuff.

Do you use illicit drugs (Marijuana, Cocaine, etc…)?
[ ] Yes Howlong?:____________________
[ ] No

♦♦

FAMILY HISTORY

Do any of your blood relatives have any of these diseases?
[ ] None
[ ] Back or Neck Problems
[ ] Rheumatoid Arthritis
[ ] Cancer
[ ] Coronary Artery Disease
[ ] high blood pressure
[ ] lung problems
[ ] diabetes
[ ] kidney problems
[ ] ulcers
[ ] heart problems
[ ] gout
[ ] epilepsy (seizures)
[ ] stroke
[ ] thyroid (too little)
[ ] thyroid (too much)
[ ] anemia
[ ] Other – Specify

♦♦

Please Do Not Write in the "Notes" section

NOTES:____

____

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REVIEW OF SYSTEMS

Please mark all of the following that apply to you.

Constitutional
[ ] Low fever
[ ] High fever
[ ] Chills
[ ] Loss of appetite
[ ] Unexplained weight loss
[ ] Unusual tiredness
[ ] Insomnia
[ ] Sedation

Eyes
[ ] blurred vision
[ ] double vision
[ ] abnormal vision
[ ] glasses
[ ] contact lenses

Ears, Nose, Mouth, Throat
[ ] ringing in ears
[ ] room spinning
[ ] dizziness
[ ] sinus pain
[ ] sinus drainage
[ ] mouth sores
[ ] sore throat

Cardiovascular
[ ] high blood pressure
[ ] angina (chest pain)
[ ] trouble breathing
[ ] trouble breathing when flat
[ ] ankle swelling
[ ] heart attack
[ ] congestive heart failure
[ ] mitral valve prolapse
[ ] abnormal heart rhythm
[ ] heart murmur / arrythmia

Respiratory
[ ] heavy cough
[ ] cough up sputum
[ ] cough up blood
[ ] pneumonia
[ ] asthma

Gastrointestinal
[ ] nausea
[ ] stomach pain
[ ] vomiting
[ ] vomiting blood
[ ] vomiting "coffee grounds"
[ ] ulcers
[ ] hiatal hernia
[ ] constipation / diarrhea
[ ] change in bowel habits
[ ] blood in stool
[ ] black, tarry stools

Genitourinary
[ ] painful urination
[ ] blood in urine
[ ] vaginal /penile discharge
[ ] impotence
[ ] loss of sexual desire
[ ] painful sex
[ ] kidney problems
[ ] one kidney
[ ] kidney failure
[ ] dialysis
[ ] kidney transplant
[ ] venereal disease
[ ] change in bladder habits
[ ] urgency / hesitancy

Date of last menstrual period:
____

Musculoskeletal
[ ] painful joints
[ ] swollen joints
[ ] redness of joints
[ ] joint infection
[ ] bone infection
[ ] gout
[ ] osteoarthritis
[ ] rheumatoid arthritis
[ ] ankylosing spondylitis
[ ] osteoporosis
[ ] osteomalacia
[ ] sore muscles
[ ] muscle spasms

Psychiatric
[ ] depression
[ ] want to die
[ ] anxiety

Endocrine
[ ] diabetes
[ ] thyroid (too little)
[ ] thyroid (too much)

Hematologic/Lymphatic
[ ] unusual sweating
[ ] unusual bleeding
[ ] easy bruising
[ ] mass (lumps or bumps)
[ ] breast lump
[ ] swollen glands
[ ] anemia
[ ] infection
[ ] HIV
[ ] AIDS
[ ] hepatitis
[ ] cancer: what type?

Integumentary (Skin)
[ ] Skin Sores
[ ] Skin Rash
[ ] Itching
[ ] Skin Cancer

Neurological
[ ] fainting
[ ] epilepsy (seizures)
[ ] stroke
[ ] memory problems

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