NEW PATIENT QUESTIONNAIRE

Spine pt acct # _____

Name: _____ Date of Visit: _____

Male ○ Female ○ **(please fill in the circles)** Date of Birth: _____

Height: _____ Weight: _____ Age Today: _____

What studies have been done on your spine? Where/When?

__ none
__ X-ray _____ __ Bone Scan _____
__ MRI Scan _____ __ EMG Nerve Study _____
__ CT Scan _____ __ Myelogram _____

Have you seen any other doctors/chiropractors for this same problem? (names and dates): _____
_____

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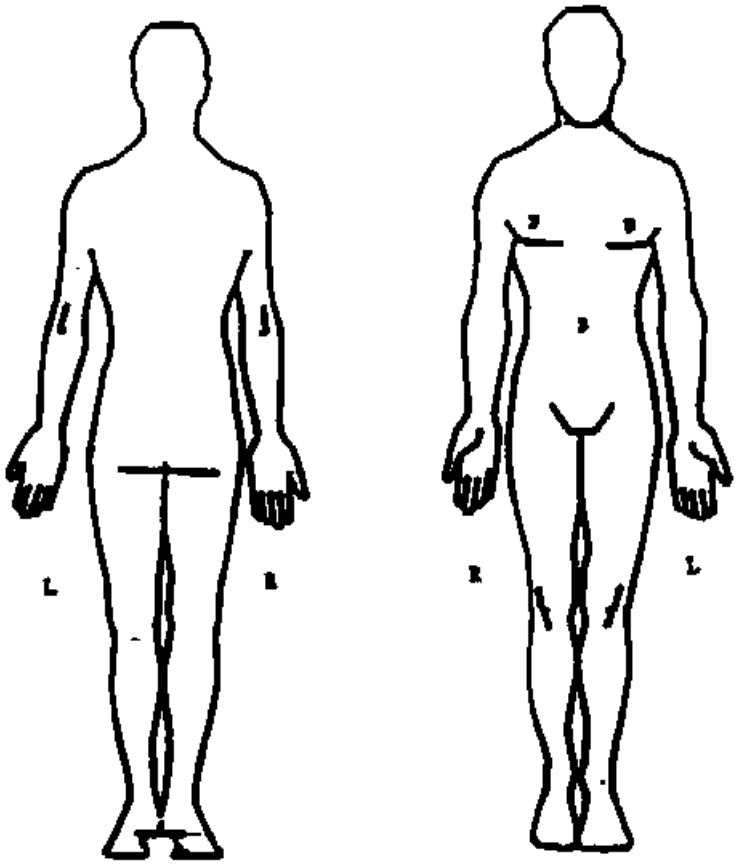
1. Pain Drawing: Mark these drawings using the symbol that best describes your pain quality

Numbness = = = = Ache ^ ^ ^ ^ Stabbing / / / / / /
Burning x x x x Cramping + + + + Pins & Needles O O O O



2. Which area is most painful?
○ Low back ○ Neck and/or ○ Both are equal

3. If you have <u>BACK</u> pain…

_____% back pain + _____% leg pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Back

	0	1	2	3	4	5	6	7	8	9	10	
None	○	○	○	○	○	○	○	○	○	○	○	Worst Pain

<u>Circle one</u>: occasional | intermittent | frequent | constant

Leg

	0	1	2	3	4	5	6	7	8	9	10	
None	○	○	○	○	○	○	○	○	○	○	○	Worst Pain

<u>Circle one</u>: occasional | intermittent | frequent | constant

4. If you have <u>NECK</u> pain…

_____% neck pain + _____% arm pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Neck

	0	1	2	3	4	5	6	7	8	9	10	
None	○	○	○	○	○	○	○	○	○	○	○	Worst Pain

<u>Circle one</u>: occasional | intermittent | frequent | constant

Arm

	0	1	2	3	4	5	6	7	8	9	10	
None	○	○	○	○	○	○	○	○	○	○	○	Worst Pain

Circle one: occasional | intermittent | frequent | constant

5. **Who referred you to S.O.Orthopedics?**
   - ○ Friend/ Family Member _____
   - ○ SpineCare Patient_____
   - ○ Internet
   - ○ Physician
   - ○ Other:_____

6. **What is the primary reason for your visit?**
   - ○ Evaluation/ Diagnosis/ Treatment
   - ○ Second opinion
   - ○ Education/ information
   - ○ Surgical planning

7. **How did your current symptoms begin?**
   - ○ Suddenly Date: _____
   - ○ Gradually

   Please describe: _____

   _____

   _____

8. **How long ago did your current symptoms begin**?
   - ○ Less than 2 weeks ago
   - ○ 3 months to less than 6 months ago
   - ○ 2 weeks to less than 8 weeks ago
   - ○ 6 to 12 months ago
   - ○ 8 weeks to less than 3 months ago
   - ○ More than 12 months ago

9. **Is this a work-related injury?**
   ○ Yes ○ No

10. **Have you ever filed a Worker's Compensation claim for your back/ neck symptoms in the past?**
    ○ Yes ○ No

    If yes, Date: _____

11. **Did your pain begin after a car accident?**
    ○ Yes ○ No (skip to question #12)

    If you were injured in a car accident please carefully fill out the questions below.

    Date of Accident: _____

    Briefly describe the details of the accident:

    _____

    _____

    Describe the pattern of symptoms over the first 1-4 weeks:

    _____

    _____

    When did you first notice symptoms?
    - ○ Immediately ○ 1-2 weeks
    - ○ 24-28 hours ○ 2-4 weeks
    - ○ 3-7days ○ > 1 month

    When did you first report these to a doctor?

    _____

    If there was a delay between the symptoms starting and your first report, please explain:

    _____

    Did you suffer any other injuries when you hurt your spine?
    ○ Yes ○ No

    If yes, please list:

    _____

12. **Have you ever been involved in a previous car accident**?
    ○ Yes ○ No

    If yes, approximate date: _____

    Was your back or neck injured?
    ○ Yes ○ No

    If yes, did the injury resolve?
    ○ Yes ○ No

    If that injury did NOT resolve, what treatment, if any, did you require on an ongoing basis?

    Explain:_____

    _____

13. **Is your pain due to an injury not covered in the questions above?**
    ○ Yes ○ No

    If yes, Date of injury: _____
    Describe injury:_____

    _____

14. Have you ever had previous back or neck surgery? ○ Yes ○ No If yes, how many surgeries? _____

Date of Spine surgery	Type of surgery	% Improvement	How long did the improvement last?

After your most recent spine surgery, did you return to work?

○ No
○ Did not work before surgery
○ Yes, with no limitations
○ Yes, with limitations

After your most recent spine surgery, did you return to full function?

○ Yes ○ No

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15. Medications and allergies

Please list all medications and doses that you are CURRENTLY taking (include herbal supplements):

Medication	Dose/ Strength	# Pills per Day	Reason

Allergies:

Medication	Reaction	Medication	Reaction

Latex Allergy? ○ Yes ○ No

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16. List all previous hospitalizations that were not for surgery: _____

_____

17. List all previous surgeries *unrelated* to your spine:

Date of surgery	Type of surgery	Describe Recovery

18. <u>Modified Oswestry Disability Index</u>: This questionnaire has been designed to give your doctor information as to how your pain as affected your ability to manage in everyday life. Please answer every question marking the ONE box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but *please mark only the box that most closely describes your current condition.*

Pain Intensity
- ○ I can tolerate the pain I have without having to use pain medication.
- ○ The pain is bad, but I can manage without having to take pain medication.
- ○ Pain medication provides me with complete relief from pain.
- ○ Pain medication provides me with moderate relief from pain.
- ○ Pain medication provides me with little relief from pain.
- ○ Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
- ○ I can take care of myself normally without causing increased pain.
- ○ I can take care of myself normally, but it increases my pain.
- ○ It is painful to take care of myself, and I am slow and careful.
- ○ I need help, but I am able to manage most of my personal care.
- ○ I need help every day in most aspects of my care.
- ○ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- ○ I can lift heavy weights without increased pain.
- ○ I can lift heavy weights, but it causes increased pain.
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ○ I can lift only very light weights.
- ○ I cannot lift or carry anything at all.

Walking
- ○ Pain does not prevent me from walking any distance.
- ○ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- ○ Pain prevents me from walking more than 1/2 mile.
- ○ Pain prevents me from walking more than 1/4 mile.
- ○ I can walk only with crutches or a cane.
- ○ I am in bed most of the time and have to crawl to the toilet.

Sitting
- ○ I can sit in any chair as long as I like.
- ○ I can only sit in my favorite chair as long as I like.
- ○ Pain prevents me from sitting for more than 1 hour.
- ○ Pain prevents me from sitting for more than 1/2 hour.
- ○ Pain prevents me from sitting for more than 10 minutes.
- ○ Pain prevents me from sitting at all.

Standing
- ○ I can stand as long as I want without increased pain.
- ○ I can stand as long as I want, but it increases my pain.
- ○ Pain prevents me from standing for more than 1 hour.
- ○ Pain prevents me from standing for more than 1/2 hour.
- ○ Pain prevents me from standing for more than 10 minutes.
- ○ Pain prevents me from standing at all.

Sleeping
- ○ Pain does not prevent me from sleeping well.
- ○ I can sleep well only by using pain medication.
- ○ Even when I take medication, I sleep less than 6 hours.
- ○ Even when I take medication, I sleep less than 4 hours.
- ○ Even when I take medication, I sleep less than 2 hours.
- ○ Pain prevents me from sleeping at all.

Social Life
- ○ My social life is normal and does not increase my pain.
- ○ My social life is normal, but it increases my level of pain.
- ○ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- ○ Pain prevents me form going out very often.
- ○ Pain has restricted my social life to my home.
- ○ I have hardly any social life because of my pain.

Traveling
- ○ I can travel anywhere without increased pain.
- ○ I can travel anywhere, but it increases my pain.
- ○ My pain restricts my travel over 2 hours.
- ○ My pain restricts my travel over 1 hour.
- ○ My pain restricts my travel to short necessary journeys under 1/2 hour.
- ○ My pain prevents all travel except for visits to the physician/ therapist or hospital.

Employment / Homemaking
- ○ My normal homemaking / job activities do not cause pain.
- ○ My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- ○ I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- ○ Pain prevents me from doing anything but light duties.
- ○ Pain prevents me from doing even light duties.
- ○ Pain prevents me from performing any job or homemaking chores

19. Do you currently smoke cigarettes?

- ○ No, I have never smoked
- ○ No, I quit ____ months/ years ago
- ○ Yes _____ packs per day
- ○ Currently Chew Tobacco/ Snuff

20. Do you use alcoholic beverages (beer, wine, liquor)?

○ Yes ○ No

If yes, type of alcohol_____

Amount _____

21. Current situation

- ○ Married
- ○ Divorced
- ○ Single
- ○ Living with significant other
- ○ Widowed

22. Do you have children?

○ Yes ○ No

If yes, list their ages:_____

How many children are living with you?_____

WORK HISTORY

23. What is your occupation? _____

Name of employer: _____

Last date worked: _____

24. Please mark ONE statement that best describes your current employment situation:

- ○ Currently working
- ○ On paid leave
- ○ On unpaid leave
- ○ Unemployed
- ○ Homemaker
- ○ Student
- ○ Retired (not due to health)
- ○ Disabled and/or retired because of my back or neck problems
- ○ Disabled due to a health problem not related to my back or neck
- ○ Other, please specify _____

PAST MEDICAL HISTORY

25. Please mark any of the following medical problems *you have had*:

- ○ Arthritis
- ○ Asthma
- ○ Cancer (Type:_____)
- ○ Depression
- ○ Diabetes
- ○ Emphysema
- ○ Heart attack
- ○ Heart disease
- ○ Hepatitis
- ○ High blood pressure
- ○ HIV positive
- ○ Kidney/bladder infections
- ○ Kidney stones
- ○ Prostate problems
- ○ Psoriasis
- ○ Seizure
- ○ Stroke
- ○ Ulcers
- ○ Ulcerative colitis
- ○ **None**

Other (Please list)_____

_____

_____

FAMILY HISTORY

26. Please mark conditions in your *immediate family*:

- ○ Anesthesia difficulties
- ○ Arthritis
- ○ Back Pain
- ○ Bleeding tendencies
- ○ Cancer
- ○ Diabetes
- ○ Heart Disease
- ○ Malignant hyperthermia
- ○ Stroke

27. Review of Systems: Please mark the circle next to your CURRENT symptoms:

Skin
○ rashes
○ psoriasis
○ bruise easily
○ abnormal lumps
○ painful breasts

Eyes
○ visual loss
○ double vision

Ears
○ decreased hearing
○ ringing in ears

Nose
○ sinus problems
○ breathing problems

Throat
○ sore throat
○ hoarseness
○ snoring

Cardiovascular
○ palpitations
○ heart murmur
○ chest pain
○ irregular heartbeat

Respiratory
○ shortness of breath
○ wheezing
○ cough

Gastrointestinal
○ weight loss
○ nausea/vomiting
○ constipation
○ diarrhea
○ blood in stool
○ loss of bowel control

Musculoskeletal
○ fractures/sprains
○ osteoporosis
○ joint swelling

Genitourinary
○ blood in urine
○ increased frequency of urination
○ painful urination
○ loss of bladder control
○ kidney stones

Endocrine
○ thyroid problems
○ excessive thirst/appetite
○ diabetes

Neurologic
○ headache/migraine
○ dizziness
○ convulsions/seizures
○ loss of consciousness