

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 the 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: _____

Primary care provider (name and medical office address): _____

Preferred pharmacy: _____

A. Location of initial pain (check all that apply): ☐ Neck pain ☐ Arm Pain ☐ Back pain ☐ Leg pain

1. How long has the pain (or your problem) been present? _____

2. 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 the 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 BACK PAIN, LEG PAIN, 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 ☐ Has 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?): _____
☐ Been on light duty since: _____

3. Previous doctors seen for this problem:

Name	Specialty	Facility/City	Treatments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Diagnostic tests done to evaluate this problem:

	Facility/City	Date
☐ X-ray:	_____	_____
☐ CT 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, Vicodin, Darvocet)
- ☐ Epidural injections: _____ times. How long did they relieve the pain for? _____

E. MEDICATIONS YOU TAKE FOR ALL HEALTH ISSUES:

☐ None

Medication

Dosage/frequency

_____	_____
_____	_____
_____	_____

F. MEDICATIONS YOU HAVE TRIED FOR YOUR SPINE PROBLEM:

☐ None

Medication

Dosage/frequency

_____	_____
_____	_____
_____	_____

G. MEDICATION ALLERGIES:

☐ None

Medication

Reaction

_____	☐ Rash ☐ Upset stomach ☐ Wheezing or shock ☐ Other: _____
_____	☐ Rash ☐ Upset stomach ☐ Wheezing or shock ☐ Other: _____
_____	☐ Rash ☐ Upset stomach ☐ Wheezing or shock ☐ Other: _____

Iodine allergy:

☐ NO

☐ YES, describe reaction: _____

H. YOUR MEDICAL HISTORY (check all that apply): ☐ None of these apply

☐ AIDS	☐ Cancer	☐ Kidney failure	☐ Rheumatoid arthritis
☐ Alcoholism	☐ Diabetes	☐ Kidney stones	☐ Serious injury: _____
☐ Anemia	☐ Gout	☐ Liver trouble	☐ Sleep apnea
☐ Ankylosing Spondylitis	☐ Heart attack	☐ Lung disease	☐ Stomach ulcers
☐ Asthma	☐ Heart failure	☐ Mental illness	☐ Stroke
☐ Bleeding disorder	☐ Hepatitis	☐ Osteoarthritis	☐ Thyroid trouble
☐ Blood clot in leg or lung	☐ High Blood Pressure	☐ Osteoporosis	☐ Tuberculosis
☐ Others: _____			

I. SURGICAL HISTORY (including spine):

Operation	Surgeon	Facility/City	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

J. INJURY HISTORY

1. Do you have a prior history of back or neck problems? _____
2. Any prior industrial or Workers' Compensation claims? ☐ YES ☐ NO
Explain: _____
3. Because of this problem, do you have or plan to have: ☐ Lawsuit ☐ Workman's Comp claim ☐ Unsure

K. SOCIAL HISTORY & HABITS:

1. Workstatus: ☐ Homemaker ☐ Working ☐ Retired ☐ Disabled ☐ On leave
2. Date last worked: _____
3. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Co-Habiting
4. I live: ☐ Alone ☐ With: _____
5. Tobacco: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes ____ pack/day for ____ years
☐ Quit, when? _____
6. Alcohol: ☐ Never/rarely ☐ Social ☐ Frequent (more than 2 times per week) ☐ Alcoholic
☐ Recovering
7. Illicit/Street drug usage: ☐ Never ☐ In the past ☐ Currently ☐ IV Drugs

L. REVIEW OF SYSTEMS (check all that apply): ☐ None of these apply

- | | | | |
|--|--|---|--|
| ☐ Abnormal heartbeat | ☐ Frequent belching | ☐ Hoarseness | ☐ Seizures |
| ☐ Blackouts | ☐ Frequent diarrhea | ☐ Hot or cold spells | ☐ Shortness of breath |
| ☐ Burning on urination | ☐ Frequent headaches | ☐ Loss of hearing | ☐ Stomach pain |
| ☐ Change of vision | ☐ Frequent rash | ☐ Nausea or vomiting | ☐ Swollen ankles |
| ☐ Difficulty urinating | ☐ Frequent urination | ☐ Nervous exhaustion | ☐ Toothache |
| ☐ Difficulty swallowing | ☐ Gum trouble | ☐ Nose bleeds | ☐ Ulcers |
| ☐ Ear pain | ☐ Heart or chest pain | ☐ Reading glasses | ☐ Other: _____ |
| ☐ Fever or chills | ☐ Hemorrhoids | ☐ Recent weight change | _____ |
- Women only: ☐ Irregular periods ☐ Vaginal discharge ☐ Frequent spotting ☐ Other: _____

Is your primary care doctor aware of the above checked problem(s)? ☐ YES ☐ NO

M. FAMILY HISTORY

List any illnesses that “run” in your family:

N. HEIGHT AND WEIGHT

Approximate height: _____ Approximate weight: _____

O. PAIN DESCRIPTION

Indicate the location and description of your pain by placing the appropriate letter symbols on the diagram below:

TYPE OF PAIN	SYMBOL
Aching	A
Burning	B
Numbness	N
Pins and needles	P
Stabbing	S

