



**SPINE DISORDERS CLINIC
INITIAL QUESTIONNAIRE**

Please answer all items and fill all blanks.

These answers will help us to evaluate and care for your back and neck problems.

Date _____

Name _____ Age _____ D.O.B. _____

Sex _____ Height _____ Weight _____ Occupation _____

Chief complaints/Main problems (List most severe first)

What do you think is the major cause of your problems?

Describe all details of any accident, incident, or the way these problems began.

Date these problems began _____ at what time day _____

Did your problems begin gradually? _____ suddenly? _____ or following:

A fall _____ Lifting _____ Twisting _____ Bending _____ Work Injury _____

Recreational Injury _____ Automobile Accident _____ or Other _____

Where did the pain start? _____

Which word best describes your pain? Dull or Sharp, Superficial or Deep, Burning,
Throbbing, Shooting, Stabbing, Aching

Have you seen any other Doctors, Clinics, E.R., Hospitals for your current spinal problem? Please List:

Name	Address	Date 1 st visit	Date last visit
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Were you admitted to the hospital? _____ How long? _____

Tests and Treatments _____

Have any treatments ever made the pain better? Yes _____ No _____ What treatments helped?

PRESENT PAIN

Where is the pain today? _____

Which word best describes your pain today? Dull or Sharp, Superficial or Deep, Burning, Throbbing, or Shooting, Stabbing or Aching, Well Localized or Poorly Localized.

Is your pain today _____ Same _____ Better _____ Worse compared to when it began?

Is your pain mainly in the Neck/Back _____ Arms/Legs _____

What is your pain ratio? (choose one)

- A. 100% Back Pain - 0% Leg Pain
- B. 75% Back Pain - 25% Leg Pain
- C. 50% Back Pain - 50% Leg Pain
- D. 25% Back Pain - 75% Leg Pain
- E. 0% Back Pain - 100% Leg Pain

- 100% Neck Pain - 0% Arm Pain
- 75% Neck Pain - 25% Arm Pain
- 50% Neck Pain - 50% Arm Pain
- 25% Neck Pain - 75% Arm Pain
- 0% Neck Pain - 100% Arm Pain

What produces or increases the pain? _____

Does your pain wake you at night? _____ Describe _____

What relieves or reduces the pain? _____

How long does each attack of pain last? _____

How often do these attacks of pain occur? Daily Weekly Monthly Yearly Constantly

Have you been in constant pain since it began? _____

Describe how your pain travels or radiates: _____

Have you noticed any Numbness _____ Tingling _____ or Sensitivity _____ with your pain?

Do your arms/legs get weak with your pain? _____

Do you have full control of your bladder and bowels? _____

Do bowel movements change your pain? _____

Does your pain affect your bladder or bowels? _____

Have you had any bladder or urinary problems with your pain? _____

Has your pain affected your sex life? _____

Which medications help your pain:

_____ Number/Each Day _____
_____ Number/Each Day _____
_____ Number/Each Day _____
_____ Number/Each Day _____

Does your pain intensity vary throughout a 24 hour period? _____

My pain is: (check appropriate box)

	Better	Worse	Unchanged
When I awaken in the morning			
When I first get out of bed			
Bending forward to brush teeth			
When stooping			
With sneeze or cough			
Sitting down at table			
Sitting in an automobile			
During the middle of the day			
Just before bedtime			
During the middle of the night			
Lying on my back			
Lying on my stomach			
Lying on my side with knees bent			
When walking			
When lifting			
When reclining			
Getting up			

Since your spinal pain began is it Increasing _____ Decreasing _____ Remains the same _____

Worse time of day _____ Best time of day _____

Preferred Position: Sit _____ Stand _____ Move _____ Walk _____

How many minutes can you: Sit _____ Stand _____ Walk _____ Ride _____

before you have to stop because of your spinal pain?

What happens to your legs when you walk? _____

How many **minutes** do you have to rest before walking again? _____

What position do you have to rest? Stand _____ Sit _____ Lying Down _____

What activities have you stopped because of this pain? (Work, Housework, Recreational, Social) Have you had any of the treatments indicated below? Mark the boxes with the following symbols. Please include how long this effect lasts. "0" for no change, "+" for better, or "-" for worse

	Not Helpful	Helpful	Duration of Effect
Back School			
Ice			
Hot Packs			
TNS Unit			
Traction			
Gravity Traction (Inversion)			
Arching Exercises			
Sit Up Exercises			
Acupuncture			
Chiropractic			
Epidural Block			
Facet Block			
Pain Pills			
Other Medications			
Other Treatment			

Please indicate on the following the degree of change.

"+" for Increase, "-" for Decrease, "0" for no Change

- | | |
|--|---|
| <input type="checkbox"/> Liquor | <input type="checkbox"/> Sleep, Rest |
| <input type="checkbox"/> Stimulants (Coffee, etc.) | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Distraction (TV, etc.) |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Urination, Defecation |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Damp | <input type="checkbox"/> Bright Lights |
| <input type="checkbox"/> Weather Changes | <input type="checkbox"/> Loud Noises |
| <input type="checkbox"/> Massage, Vibrator | <input type="checkbox"/> Going to Work |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Intercourse |
| <input type="checkbox"/> No Movement | <input type="checkbox"/> Mild Exercise |
| <input type="checkbox"/> Movement | <input type="checkbox"/> Fatigue |

Choose the number of the word which best describes your pain:

- (1) Mild, (2) Discomforting, (3) Distressing, (4) Horrible, (5) Excruciating

- | | |
|---|--|
| <input type="checkbox"/> Your pain right now | <input type="checkbox"/> The worst toothache you ever had |
| <input type="checkbox"/> Your pain at its worst | <input type="checkbox"/> The worst headache you ever had |
| <input type="checkbox"/> Your pain at its least | <input type="checkbox"/> The worst stomach ache you ever had |

Please answer the following questions	Yes	No	Please list the last date procedure was performed
Have you had a Myelogram?			
Have you had an MRI?			
Have you had a CT Scan?			
Have you had a Bone Scan?			
Have you had plain x-rays?			
Have you had Discograms?			
Have you had Facet Blocks?			
Have you had Epidurals?			
Have you had an EMG test?			
Have you had previous Spinal Surgery?			How Many?

List all previous spinal surgeries:

Date	Surgeon	Main Complaint before Surgery	Benefits of Surgery	Time Off	Duration of Relief

Have you needed an attorney for any of your previous spinal episodes, injuries or spinal surgeries?

Name of Attorneys: _____

Outcome of legal action: _____

Have you ever had to sue any doctors or hospitals? _____

Details: _____

Do you plan to sue any doctors or hospitals? _____

Details: _____

Do you have an attorney for this episode of pain? _____

List name, address and telephone of Attorney: _____

Date of first contact with Attorney _____ Reason for Attorney _____

Do you have a court hearing soon? _____

List the people who need a copy of any Medical – Legal reports: _____

Work History

When did you last work or do your normal activities? _____

Describe in detail your work and daily activities before this episode: _____

How many hours worked: _____ Day _____ Week

Describe your work and daily activities now: _____

Have you returned to work? _____ Date _____

Have you been released back to work? _____ Date _____

Normal duties? _____ Medium duties? _____ Light duties? _____

Have you been dismissed? _____

Time on this job before this episode? _____

Do you plan to return to this job? _____

What will it take for you to return to work? _____

Have you lost any other time off work for other episodes of spinal pain? _____

Give details: _____

Past Medical History

Childhood Illnesses: Please circle those that apply:

Measles Mumps Chickenpox Diphtheria Whooping Cough Strep Throat

Polio Rheumatic Fever Heart Murmur Other: _____

Circle if you currently have or have previously suffered from:

High Blood Pressure	_____ Yes	_____ No	When _____
Diabetes	_____ Yes	_____ No	When _____
Thyroid Condition	_____ Yes	_____ No	When _____
Seizures	_____ Yes	_____ No	When _____
Liver Disease	_____ Yes	_____ No	When _____
Heart Attack	_____ Yes	_____ No	When _____
Stroke	_____ Yes	_____ No	When _____
Arthritis	_____ Yes	_____ No	When _____
Cancer	_____ Yes	_____ No	When _____

Other: _____

Have you ever had any surgery? _____ Yes _____ No If yes, give part of body, type of operation,

Name of surgeons and dates: _____

Any other hospitalizations? Reason, Dates and Doctors Name: _____

Allergies: Please circle those that apply:

Asthma Hayfever Hives Eczema Pollen

Please list all allergies to food: _____

Please list all allergies to drugs: _____

Please list anything else: _____

Are you taking any medications now for any reason? _____ Yes _____ No

If yes, please give name and for what condition: _____

Review of Systems

Check any of the following medical problems you have now:

Neurological

- Loss of Consciousness
- Paralysis
- Changes in Taste/Smell
- Tremors
- Gait Disturbances
- Headaches

Respiratory

- Cough
- Flu
- Chest Pains
- Pneumonia
- Wheezing
- Blood Clots in Lungs
- Pain with Breathing
- Fever
- Chills

Cardiovascular

- Shortness of Breath
- Palpitations
- Swelling
- Leg Pains
- Swelling/Vein Pain
- Shortness of Breath When Lying down
- Chest, Arm, or Neck pain or pressure with Exertion

Gastrointestinal

- Difficulty Swallowing
- Heartburn
- Nausea & Vomiting
- Blood in Bowel Movements
- Abdominal Pain
- Jaundice
- Changes in Bowel Habits
- Diarrhea
- Constipation
- Loss of Control
- Hepatitis
- Ulcer (Type _____)
- Recent Weight Gain
- Recent Weight Loss

Genitourinary

- Increased Urination
- Urination During Sleep
- Pain During Urination
- Inability to Urinate
- Dribbling
- Loss of Control
- Stones
- Discharges
- Venereal Disease
- Sexual Difficulties
- Pain with Intercourse
- Pelvic Pain
- _____ Date of Last Normal Sexual Activity

Musculoskeletal

- Backache
- Joint Pain
- Stiffness
- Fractures
- Joint Swelling
- Muscle Weakness
- Sleep Difficulty
- Hours of Sleep each Night
- Sleep Medication

Are you right or left handed? _____

List your hobbies and recreational activities: _____

List daily exercise activities and time spent at each per day: _____

How often do you walk outside? _____ per week?

How long each time? _____

How often do you perform spinal exercises? _____ per week?

How long each time? _____

Spinal Disorders Clinic

"Patient Needs" Questionnaire

Today's Date _____ Patient Name _____
Injury Date _____ Patient Number _____
Patient's Age _____ Date of Birth _____

As we are attempting to satisfy your needs and expectations, please complete the following questionnaire:

What is the purpose of your clinic visit today? _____

What do you need before you leave today? _____

Initial comprehensive evaluation:

Diagnosis _____ Surgical Treatment _____ Non-Surgical Treatment _____

Follow-up Evaluation:

Special Studies Results _____ Post Treatment _____ Postoperative _____

Second Opinion:

Diagnosis _____ Surgical Treatment _____ Non-Surgical Treatment _____

Medication:

Pain _____ Narcotics _____ Anti-Inflammatory _____ Other _____

Special Orthotics:

Brace _____ Support _____ Belt _____

Fitness Report:

Work _____ School _____ Other _____

Absentee Report:

Work _____ School _____ Other _____

Insurance Forms:

Health _____ Disability _____ Car Loan _____ House Loan _____ Other _____

Disability Evaluation & Report:

Social Security _____ Dept. Labor _____ Workers Comp _____ Personal Injury _____ Other _____

Part II

Pain Pattern Chart

Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.

Please place the following letters next to the areas of your pain. These letters represent the type of pain you are experiencing.

(A): Aching (B): Burning (N): Numbness (P): Pins & Needles (S): Stabbing (O): Other

Percentage of pain in back/neck: _____

Percentage of pain in legs/arms: _____

Front



Back



Mark Your Pain Estimate

No Pain |-----| Intolerable Pain

Name _____ Date _____

Please Read: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relates to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain and I do not use them.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 7 – Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than six hours sleep.
- Even when I take tablets I have less than four hours sleep.
- Even when I take tablets I have less than two hours sleep.
- Pain prevents me from sleeping at all.

Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, eg 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.

Section 8 – Sex Life

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ½ mile.
- Pain prevents me walking more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 9 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of my pain.

Section 5 – 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 sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 10 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 min.
- Pain prevents me from traveling except to the Dr. or hospital.

Comments _____

