

Date: \_\_\_\_\_

### SPINE CARE QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_

work     home

Spouse: \_\_\_\_\_ Children: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Consult \_\_\_\_\_ Worker's Compensation  
  \_\_\_\_\_ Motor Vehicle Accident \_\_\_\_\_ Litigation

Referred by: \_\_\_\_\_ Phone number: \_\_\_\_\_

General Health: \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Medications: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Smoke:  Yes  Packs/day \_\_\_\_\_  Since 19 \_\_\_\_\_  
  No  Quit in 19 \_\_\_\_\_  Previous packs/day \_\_\_\_\_  Since 19 \_\_\_\_\_

#### BACK HISTORY

Date of Injury: \_\_\_\_\_

Type of Injury: \_\_\_\_\_ fall \_\_\_\_\_ car accident \_\_\_\_\_ lifting \_\_\_\_\_ overuse

Pain Description: \_\_\_\_\_ constant or \_\_\_\_\_ intermittent  
   \_\_\_\_\_ dull ache or \_\_\_\_\_ sharp stabbing or \_\_\_\_\_ fatigue  
   \_\_\_\_\_ radiating pain left/right arm/leg  
   \_\_\_\_\_ radiating pain to buttocks, thigh, or leg

#### CIRCLE ONE

YES or NO:  awakens you from sleep  
YES or NO:  increased pain with sneezing and coughing  
YES or NO:  pins and needles sensation in lower extremity or in upper extremity (circle)  
YES or NO:  bowel or bladder loss of control

PRIOR SURGERIES: (Circle and date)

DISCECTOMY, LAMINECTOMY, SPINAL DECOMPRESSION OR FUSION

Date: \_\_\_\_\_ Pain Relieved? \_\_\_\_\_  
       For how many months or years?

Date: \_\_\_\_\_ Pain Relieved? \_\_\_\_\_  
       For how many months or years?

TREATMENTS:

- \_\_\_\_\_ Anti-inflammatory medications: (circle)  
 Naprosyn, Motrin, Voltaren, Feldene, Relafen, Anaprox, Ansaïd, Clinaril, Indocin,  
 Toradol  
\_\_\_\_\_ Physical therapy: (circle)  
 -Heat, Cold, Massage, Ultrasound, Electrical stimulation  
 -Traction  
 -Exercise, Body Mechanics, Posture Training  
 -General fitness training  
\_\_\_\_\_ Nerve root block  
\_\_\_\_\_ Facet block  
\_\_\_\_\_ Epidural injection  
\_\_\_\_\_ Bracing  
\_\_\_\_\_ Alternative care (Chiropratic, acupuncture, biofeedback)

DIAGNOSTIC STUDIES:

- \_\_\_\_\_ Plain X-rays \_\_\_\_\_  
    Hospital      Date  
\_\_\_\_\_ MRI    
    Hospital      Date  
\_\_\_\_\_ CT Scan   
    Hospital      Date  
\_\_\_\_\_ Myelogram   
    Hospital      Date  
\_\_\_\_\_ Discogram   
    Hospital      Date

BACK PAIN: (circle one)

1. This pain is an (annoyance or disabling) pain. RATE: None-1-2-3-4-5-6-7-8-9-10-Severe  
(Circle one)

2. This pain is \_\_\_\_\_ A (back or neck) and \_\_\_\_\_ B (leg or arm) pain  
% of 100%   % of 100% (A+B=100%)

3. I am (able or unable) to enjoy life and complete my daily activities of living

4. I am only able to walk 95 feet, 250 feet, 5 blocks, unlimited before stopping to rest.  
(Circle one)

5. I am able to enjoy socializing and my hobbies.  YES or NO

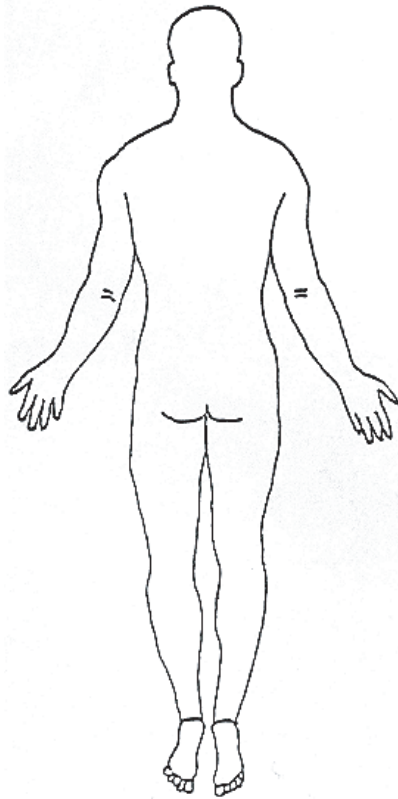
## PAIN DISTRIBUTION DRAWING:

□ Assume the diagram is a representation of your body. Use colored pens to match the symptoms listed below with the diagram. Use the color net to the symptom, then color in the area on your body where it applies. Try to color between the lines.

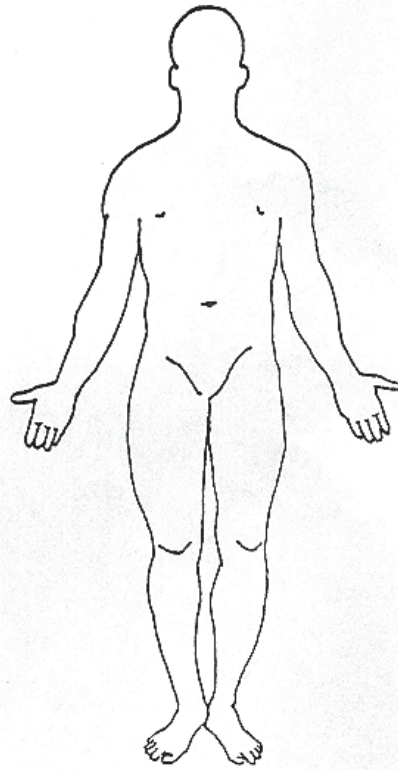
**Red**- Pins and needles sensations

**Blue**- Sharp stabbing pain

**Green**- Dull, aching/cramping sensations



Back



Front