ORTHOPAEDIC SPINE PAIN QUESTIONNAIRE

NAME:___________________________________________________ DATE:____________________

ADDRESS:____________________________________________________________________________

AGE:_______ TELEPHONE#:________________________________ RELIGION:________________________

OCCUPATION:________________________________ REFERED BY WHOM:________________________

NEAREST FRIEND/RELATIVE:________________________________ TELEPHONE#:

ADDRESS:____________________________________________________________________________

________________________________________________________

PLEASE EXPLAIN WHY YOU HAVE COME TO SEE US AND WHAT YOU WOULD LIKE US TO DO FOR YOU (USE ONLY THE LINES PROVIDED):

____________________________________________________________________________
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Please mark the areas on the diagram below where you feel the described sensations on your body. Use the appropriate symbols. Mark the areas of radiation. Include all affected areas.
Aching (AAA)
Numbness (======)
Pins and Needles (000)
Burning (XXX)
Stabbing (///)
THE FOLLOWING GENERAL MEDICAL INFORMATION WILL HELP YOUR PHYSICIAN. PLEASE READ THROUGHOUT THE LIST AND CIRCLE ANY SYMPTOMS THAT YOU HAVE.

Eyes: (pain, burning, double vision)

Ears: (ringing, pain, loss of hearing)

Nose: (chronic discharge, nosebleeds)

Mouth: (dry, chronic sores)

Chest: (pain, cough, shortness of breath with normal activity, shortness of breath in bed, heart palpitations)

Breasts: (masses, discharge)

Abdomen: (need to avoid certain foods, pain, cramps, diarrhea, constipation, change in stool)

Urine: (burning or urination, change in color or nature of urine, need to get up at night to urinate)

Musculoskeletal: (back pain, pain or swelling in any joints, pain with changes in weather)

Other: (headaches, loss of energy, loss of weight, change in appetite, difficulty sleeping, change in skin, depression, thoughts of suicide, desire to see a psychiatrist, difficulty tolerating hot or cold)

For Women: Please note the date of your last menstrual cycle and any irregularities:

Date: ________________________________________________________________

Irregularities: ______________________________________________________

List all non-spinal operations and the year in which they were done:

List all medications that you currently take:

List any allergies or bad reactions to medications:
Please circle all of the illnesses below that apply:

Hypertension (high blood pressure); Diabetes, Kidney disease, Liver disease, Lung disease (breathing disorders); bleeding problems; Heart disease; Circulatory problems; Cancer (tumor); Infection; Thyroid problems; history of blood clots; Seizures.

Do you smoke cigarettes, pipes, cigars: YES _______ NO _______

List all hospitalizations except for surgery:

Family history of medical illness/anesthesia complications:

List all other significant illness or diseases other than minor colds and common childhood diseases:

When was your very first back (and leg) pain or your neck (and arm) pain? Please include dates if possible.

When was your last attack of back (and leg) or your neck (and arm) pain? Please include dates if possible.

What were you doing at the time? (First and last episode)

Did it come on gradually or suddenly? (circle one)

Was there an associated injury or accident? Yes  No

If yes, describe briefly.

Is the pain constant during the entire day?
Do you have pain every day?

How long does the pain last?

Any problems with bladder (urine) control? Yes No

Any problems with bowel control? Yes No

Please circle the following activities that make the back/leg or neck/arm pain worse:

Coughing Standing Walking Running Sneezing Driving a car

Riding Riding in a plane Strain with bowel movements Sitting Lying down

Lifting Putting on shoes Other (please specify) ____________________________

______________________________________________________________________________
______________________________________________________________________________
Please circle any of the following that relieves pain:

Rest   Heat   Hot   Tens   Manipulation   Massage   Exercise
Brace/Corset   Drugs/Medication   Other (please specify) ______________
______________________________________________________________________________

Do you wear a lumbar corset (back brace)? Yes    No
Have you received any physical therapy?    Yes    No
Have you received chiropractic manipulations:    Yes    No    Dates ______________
Has the spine pain prevented you from doing your work or going to school?    Yes    No
How many times? ______________    For how long? ______________
Have you had previous similar troubles with your spine?    Yes    No
If yes, how much and when did it occur? ______________
______________________________________________________________________________

Do you have chill(s)? Yes    No
Do you have fever? Yes    No
Do you walk normally? ______________________________
How far can you walk without leg pain? (circle one)
Less than 1 block    Less than 2 blocks    Less than 5 blocks
If you have pain after walking, what do you do to relieve it? (circle one)
Stop and stand.    Stop and sit.    Stop, sit and lean forward.    Lie down.

Does your spine hurt when you bend forward?    Yes    No
Does your spine hurt when you bend backward?    Yes    No
Is your leg or ankle weak?    Yes    No
Does your back or neck hurt during intercourse?    Yes    No
Does your condition interfere with your sex life otherwise?  Yes  No

Have you ever had pain in your joints?  Yes  No

Is the following question, circle the number which is most appropriate for you?

Example: If you feel severe pain as a result of your back problem, Circle 7
If you feel no pain at all, Circle 1
If you feel moderate pain, Circle 4
If you feel some pain, but it is less than a moderate amount, Circle 2 or 3
If your pain is greater than a moderate amount, but less than severe,
Circle 5 or 6

How much pain do you feel as a result of your neck or back problem?
1 (no pain)  2  3  4 (Moderate pain)  5  6  7 (Severe pain)

What are the results of any X-ray, Myeleogram, CAT scans that you know about?

Diagnosis: __________________________________________________________

Approx. Date: _______________________

What spine surgery(s) have you had for your condition?

Martial Status (please check one)

Single  _____  Married  _____  Widowed  _____  Divorced  _____

Spouse's Age: ______  Number of Children: _______________
Your Education:
List last grade attended
Elementary School _____
High School _____
Vocational School _____
Technical School _____
College (number of years) ______
Graduate School _____
Please list all your sports activities and hobbies:

Are you currently employed?  Yes  No
Is your employment: Part-time _____  Full time _____
Hours per week: __________________________________________
Please describe your present job: ___________________________________

Is your spouse working?  Yes  No
If yes, what does he/she do for a living?
Has your spine problem has any effect on your job?
If yes, please explain.

Have you had to change jobs due to your spine problems?  Yes  No
If you were working as a homemaker before you had a spine problem, are you still able to do work at home?  Yes  No

Who helps with the housework if you do not do it yourself?

Have you received financial compensation because of your back problems?  Yes  No
If yes, what type? (circle) Social Security  Workman’s compensation  Insurance
Other: (please specify) 

What is the approximate amount received?

Are you involved in any lawsuits or other litigation related to your condition? Yes  No
If Yes, please explain:
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