

PLAS T. JAMES, MD

Spine Pain Questionnaire – Date: _____

Patient Information

Name: _____ DOB: _____ Age: _____

Referred By: _____ Phone: _____

Emergency contact (name + phone #): _____

Religion: _____ Occupation: _____

Chief Complaint

Pain: Neck Back
 Arms (right / left / both) Legs (right / left / both)

Duration: Weeks Months Years

Onset: Gradual Sudden

Cause: No injury Work injury Motor vehicle accident

Other: _____

Previous similar issue? No Yes When: _____

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

Pain Diagram + Symptoms

Diagram: Mark sensations/ symptoms on the diagram using the following symbols-

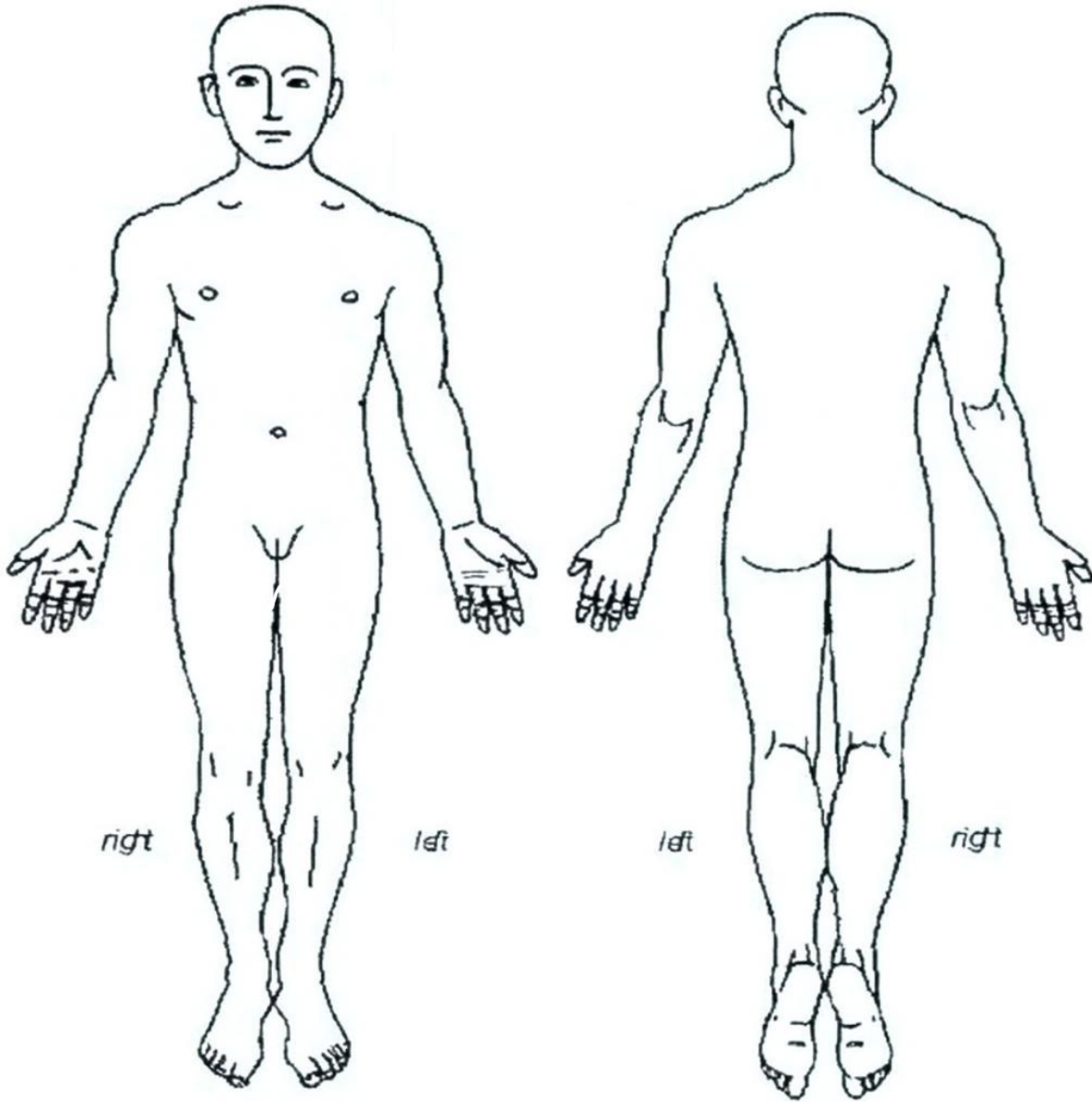
stabbing: /////

burning: xxxxx

numbness: =====

pins and needles: 0000

aching: AAAA



List all medications you currently take: _____

List any medication allergies or bad reactions: _____

REVIEW OF SYSTEMS – check any symptoms you have:

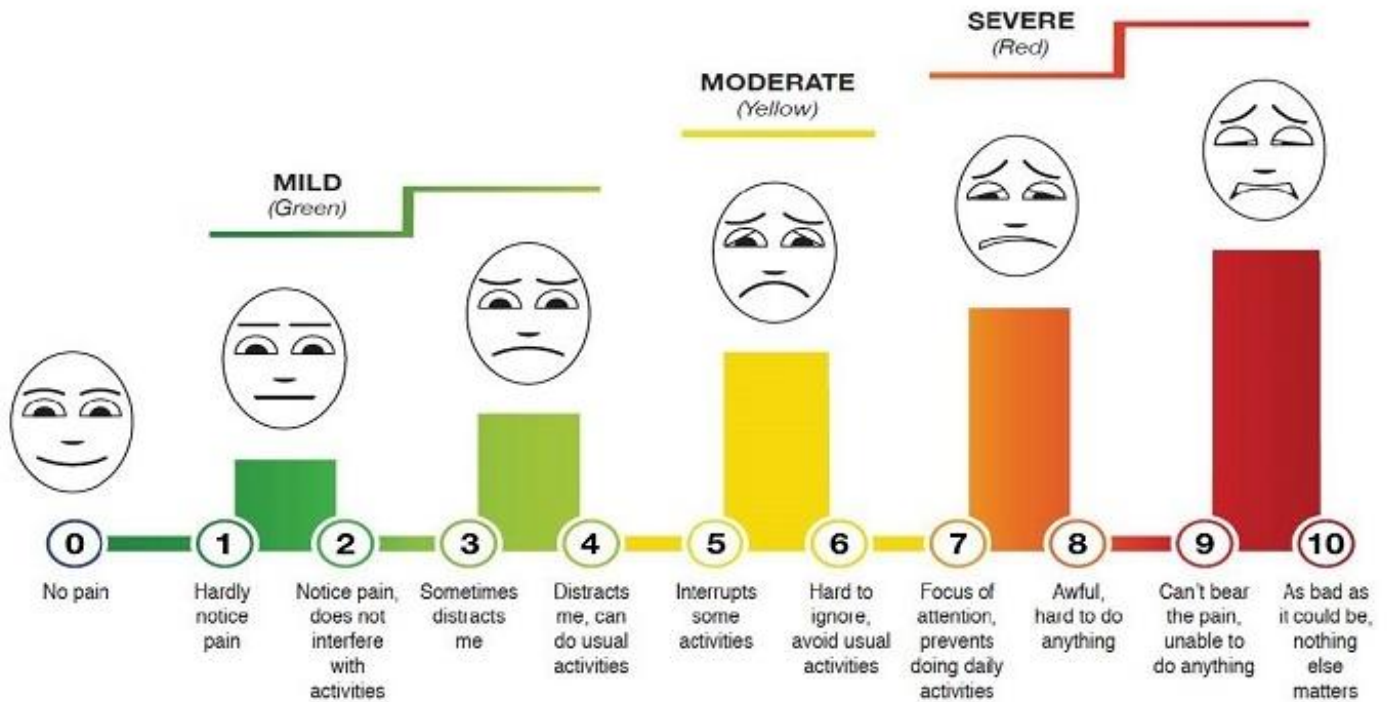
- EYES:** pain burning double vision
- EARS:** ringing pain hearing loss
- NOSE:** chronic discharge nosebleeds
- MOUTH:** dry mouth chronic sores
- CHEST:** chest pain cough heart palpitations
- shortness of breath with normal activity shortness of breath in bed
- BREASTS:** masses discharge
- ABDOMEN:** abdominal pain cramps diarrhea constipation
- change in stool need to avoid certain foods
- URINE:** burning with urination change in color/ nature of urine
- needing to get up from sleep to urinate
- MUSCULOSKELETAL:** pain/ swelling in joints pain with weather changes
- OTHER:** headaches loss of energy change in appetite
- weight loss difficulty sleeping change in skin
- depression thoughts of suicide desire to see a psychiatrist
- difficulty tolerating hot/ cold
- FOR WOMEN:** Date of last menstrual period: _____
- List any cycle irregularities: _____

CHRONIC CONDITIONS – check all illnesses that apply:

- diabetes hypertension/ high blood pressure kidney disease liver disease
- asthma lung disease/ breathing disorders bleeding issues heart disease
- seizures infection thyroid issues circulatory/ vein issues
- history of DVT cancer/ tumor (circle: active | in remission | NED)
- HIV other: _____

List all spine operations and the year performed: _____

List all non-spinal operations and the year performed: _____



Pain Assessment (from 0-10 - refer to scale above)

- Worst: _____ / 10
- Best: _____ / 10
- Usual: _____ / 10

Pain Characteristics

First episode of pain: _____ Most recent episode of pain: _____

Frequency: Constant Intermittent Occasional

Trend: Improving Worsening Stable/ unchanged

Worst when: Getting up End of day Changing position

Do you have pain in your joints? Yes No

Check all that apply:

Weakness: Arms Legs Hands Feet

Numbness/Tingling: where? _____

loss of bladder/bowel control walking issues cane/walker/wheelchair use

Do you have chill(s)? Yes No

Do you have a fever? Yes No

↑ Increases pain:

- coughing standing walking running sneezing riding in plane/ car
 driving lifting sitting laying down putting on shoes
 straining with bowel movements other: _____
-

↓ Relieves pain:

- rest heat hot baths TENS unit chiro massage
 physical therapy brace medications _____
-

Prior treatments:

Are you currently taking any medications for your back/ neck pain? _____

Which medications have you tried in the past for your back/ neck pain? _____

Have you tried: physical therapy epidural steroid injections chiropractic manipulation
 brace/ corset other: _____

What are the results of any imaging you've had for this condition (x-rays, MRI, CT, etc.)? _____

Functional Impact

- Has your spine issue had any effect on your current job? Yes No
Have you had to change jobs due to your spine issue? Yes No
Has your pain prevented you from going to work/ school? Yes No
Do you have issues completing your normal daily activities? Yes No
If you cannot complete your daily activities, do you have help? Yes No

Functional Impact (continued)

- Can you walk normally? Yes No

How far can you walk without leg pain?

- less than 1 block less than 2 blocks less than 5 blocks

If you have pain while walking, how do you relieve it?

- stop and stand stop and sit stop, sit and lean forward
 lie down _____

- Does your spine hurt while bending forward? Yes No
- Does your spine hurt while bending backward? Yes No
- Is your leg or ankle weak? Yes No
- Is your arm, wrist or hand weak? Yes No
- Does your back/ neck hurt during intercourse? Yes No
- Does your condition interfere with your sex life otherwise? Yes No

Lifestyle & Social History

Marital status: single married widowed divorced

Spouse's age: _____ Number of children: _____

Is your spouse working? yes no

(if yes) what do they do? _____

Education: grade school high school vocational/ technical school
 college (# years _____) graduate school

Please list your sports/ hobbies/ activities: _____

Are you currently employed? yes no

Is your employment: part-time full-time

Hours per week: _____

Please describe your present job: _____

- Has your spine problem had any effect on your job? yes no
- 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 work in the home? yes no
- Who helps with housework if you are unable to do it yourself? _____
- Have you received financial compensation for your spine issue? yes no
 - If yes, what kind?
 - workman's compensation social security
 - insurance personal injury
 - other: _____
 - What is the approximate amount received? _____
- Are you involved in any lawsuits or litigation related to your condition? yes no