ORTHOPAEDIC SPINE PAIN QUESTIONNAIRE

NAME:____ DATE: _____________________

ADDRESS: ____

AGE: _______ TELEPHONE#: _______________________________RELIGION: __________________________

OCCUPATION: ______________________________ REFERRED 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.

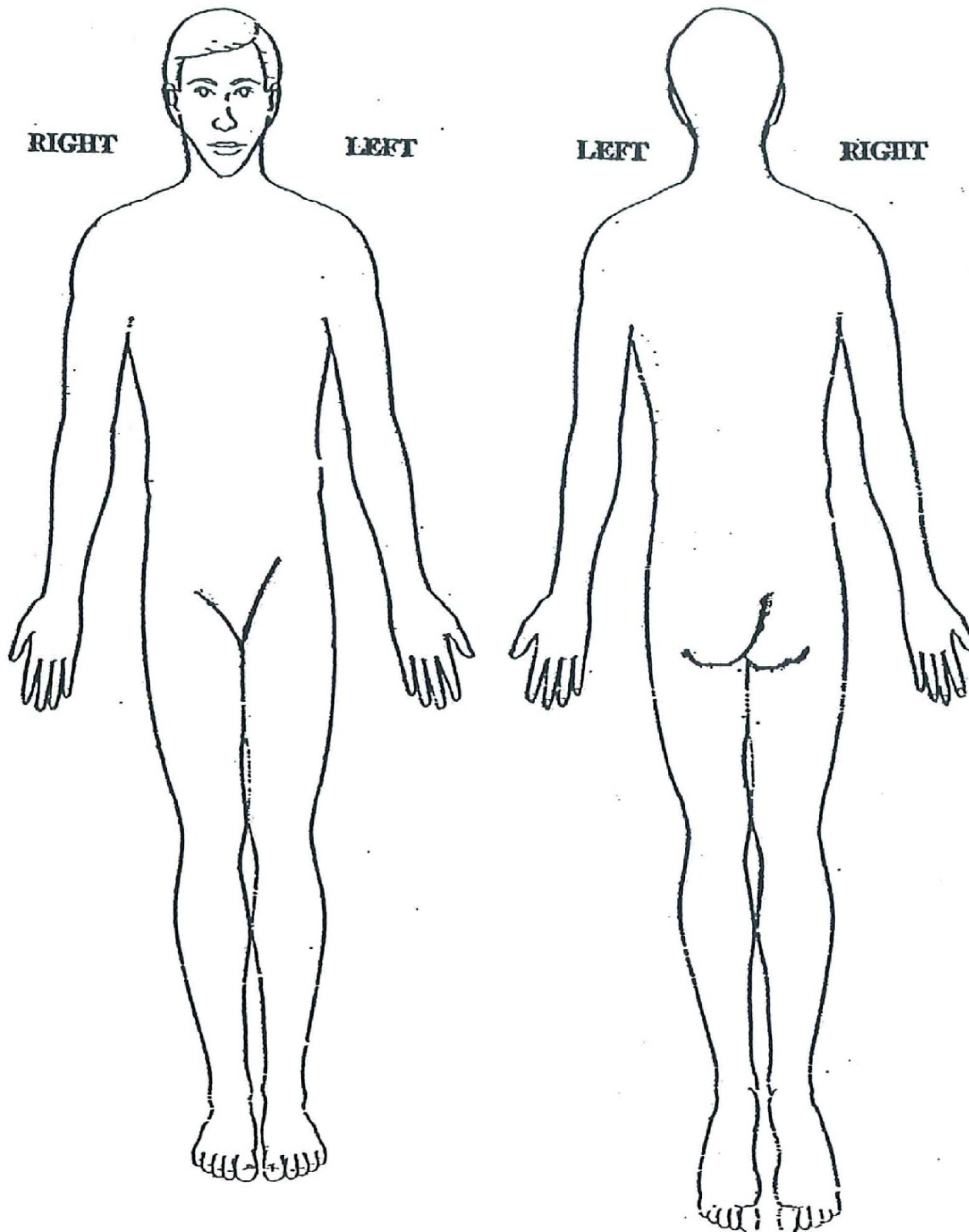
Aching (AAA)

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) ______________________________
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Please circle any of the following that relieves pain:

Rest Heat Hot Tens Manipulation Massage Exercise

Brace/Corset Drugs/Medication Other (please specify) _________________

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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 th 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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