TWIN CITIES ORTHOPEDICS

Spine Pain Questionnaire

Patient Sticker

Patient Name: ____ Date: ______________

Referred By: ____

Date of Birth: _________________ Height: _____________ Weight: ___________ Age: ________

What is the reason you are seeing the orthopedic surgeon:

Evaluation and treatment 2nd opinion Disability rating

History of Current Problems.

1. Date that your back or neck problems started? ____
2. Have you had a similar problem in the past? No Yes If yes, when ______________
   Please describe: ____
3. Is your current problem the result of a: No injury that you know of Work injury
   Motor vehicle accident Other injury If an injury, give **Date of Injury?** ______________
4. Has litigation or claim for compensation been initiated? No Yes
5. Please briefly describe how your current back/neck and/or leg/arm problems first began:

____

____

Symptom (Pain) Diagram – Please use the diagrams below to indicate the area of your symptoms and the type of symptoms you are experiencing. Use the appropriate symbol. Include all affected areas.

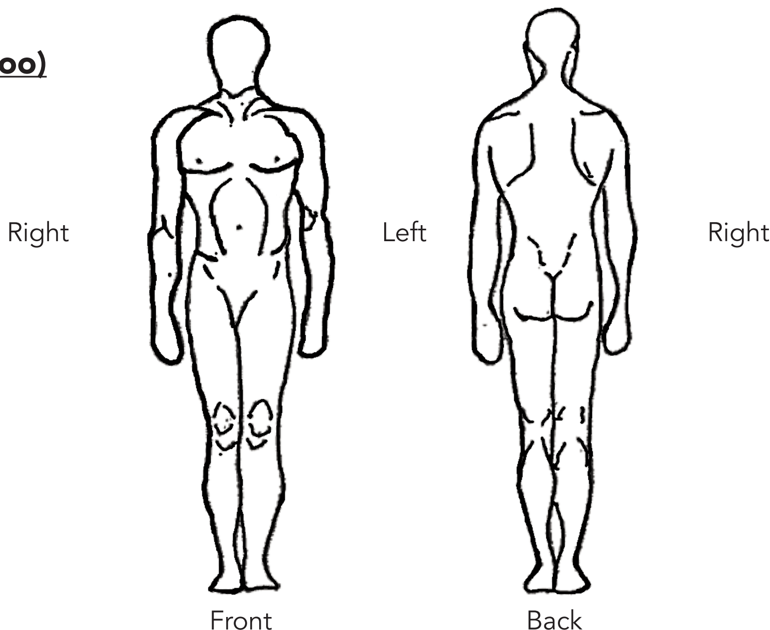
Aching Pain (xxx)

Sharp Pain (///)

Numbness (+++)

Pins/Needles (ooo)

Burning (BBB)



How much of your problem is in your back or leg? **Back** ______ % + **Leg** _____ % **= 100%**

If you have pain in your legs, which is worse: Right ______ Left ______ Equal ______

How much of your problem is in your neck or arm? **Neck** ______ % + **Arm** ______ % **= 100%**

If you have pain in your arms, which is worse: Right ______ Left ______ Equal ______

Description of Symptoms

Pain Scale: 0 = No Pain 10 = Worst Pain Possible

1. When my pain is at its worst, it is a ________________ (Pick a number from the above pain scale).
2. When my pain is at its best, it is a ________________ (Pick a number from the above pain scale).
3. Most of the time, my pain is a ________________ (Pick a number from the above pain scale).
4. Have you noticed weakness in any muscles since your problem began? No Yes*
   *If yes, please describe: ________________________________
5. How far do you estimate you can walk? _______ Feet or _______ Miles or Unlimited

Treatment

What medications are you currently taking for your pain? ________________________________

____

What medications have you taken in the past for your pain? ________________________________

____

List the physicians you have seen for this problem. ________________________________

____

How many times have you been treated by the following professionals?

Physical Therapist: ________. When? ______________. Chiropractor: ________ When? ______________

Have you had any of the following spinal treatments?

Epidural Steroid Injections Trigger-Point Injections Facet Injections Other: ____________

When? ______________ When? ______________ When? __________ When? ______________

Please list any surgeries you have had on your spine?

Date	Surgeon	Procedure

Check any of the following tests or studies you have had and give the date they were done.

X-Ray ________________________ CT Scan ________________________

MRI Scan ________________________ EMG Test ________________________

Discogram ________________________ Bone density ________________________

Other ________________________ None of the above