

Spine Questionnaire

Date: _____

Patient Name: _____ Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What is the reason you are seeing the orthopedic surgeon (check all that apply):

- Surgery Non-surgical treatment 2nd opinion Disability rating.

History of Current Problems

Date that your neck or back problems started? _____

Have you had a similar problem in the past? No Yes. If yes, when? _____

Please describe: _____

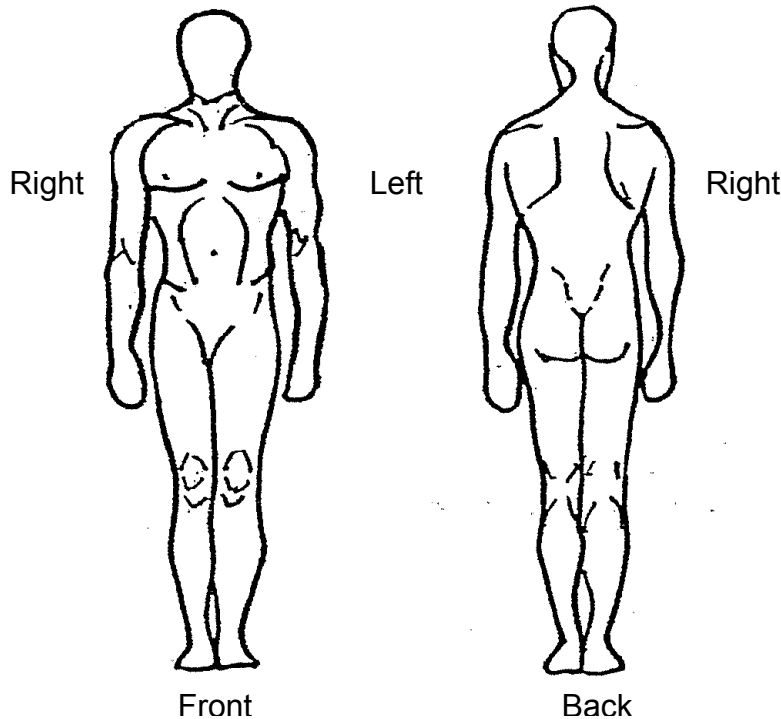
Is your current problem the result of: No injury that you know of Work injury

Motor vehicle accident Other injury If an injury, give **the date:** _____

Has litigation or claim for compensation been initiated? No Yes

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 areas in which you are experiencing symptoms. Include all affected areas. Leave blank if your condition is not painful or symptomatic.



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

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

Treatment

What medications are you currently taking for pain? _____

What medications have you taken in the past for pain? _____

List the physicians that 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 treatments?

Epidural Steroid Injections Trigger-Point Injections Facet Injections Other: _____
When? _____. When? _____. When? _____. When? _____

Please list any and all surgeries you have had on your spine:

<u>Date</u>	<u>Surgeon</u>	<u>Procedure</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

X-Ray _____ CT Scan _____
 MRI Scan _____ EMG Test _____
 Discogram _____ Others _____

Work/Social History

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Children: Yes No How many? _____ Ages _____

Do you live alone with family assisted living nursing home other _____.

Occupation _____ Employer _____ How long? _____

Are you currently working? Yes No If no, when did you last work? _____

Is your regular work? Heavy Medium Light Sedentary.

Are you currently on any work restrictions? Yes No If yes, what are they? _____

How far do you estimate you can walk? _____ City blocks or _____ Miles, or Unlimited