Adventist Health | Northern California Spine Institute

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SPINE PATIENT QUESTIONNAIRE

Please answer the following questions with the most accurate response possible. If some of the questions are unclear or do not apply, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your visit, and you can clarify your answers at that time. Thank you.

Name: _____Date: _____

Age: _____ ❑ Male ❑ Female Occupation: _____

Referred by:

_____

Family / Primary MD (location):

_____

A. 1. Location of initial pain *(check all that apply)*: ❑ Neck pain ❑ Arm pain ❑ Back pain ❑ Leg Pain

2. How long has the pain (or your problem) been present? _____

3. What started the pain/problem? _____

B. For patients with NECK OR ARM PAIN ONLY: (for back pain, skip this section and go to "C")

1. Does pain go into arms? _____% Left _____% Right
2. Raising the arm: ❑ improves the pain ❑ worsens the pain ❑ no change
3. Moving the neck: ❑ improves the pain ❑ worsens the pain ❑ no change
4. There is: ❑ Weakness in the arms or hands ❑ NO weakness in the arms or hands
5. There is: ❑ Numbness in the arms or hands ❑ NO numbness in the arms or hands
6. Do you have difficulty picking up small objects or buttoning your buttons? ❑ YES ❑ NO
7. Do you have problems with balance, or trip frequently? ❑ YES ❑ NO

END OF NECK OR ARM PAIN QUESTIONS, PLEASE GO TO "D"

C. For patients with BACK PAIN, LEG PAIN, NUMBNESS OR WEAKNESS.

1. What percent of your pain is back pain (from mid-back to buttocks)? _____%
2. What percent of your pain goes down your leg? ❑ Left_____% ❑ Right _____%
3. Do you have pain that "shoots" or goes below your knees? ❑ YES ❑ NO
4. There is weakness of my: _____
5. There is numbness of my: _____
6. The worst position for my pain is: ❑ Sitting ❑ Standing ❑ Walking
7. How many minutes can you stand in one place without pain? _____minutes
8. How many blocks can you walk without pain? _____blocks
9. Lying down: ❑ Eases my pain ❑ Makes my pain worse ❑ No effect

D. ALL PATIENTS should answer the following:

1. There is: ❑ NO loss of bowel or bladder control ❑ Loss of control since: _____
2. I have: ❑ NOT missed any work because of this problem ❑ Missed work (how much?): _____
   ❑ Have been on light duty (since?): _____
3. Previous doctors seen for this problem:

Doctor	*Specialty*	*City*	*Treatments*

4. Diagnostic tests done to evaluate this problem:

	City	*Date*
❑ X-ray:		
❑ Cat Scan:		
❑ Myelogram:		
❑ MRI:		
❑ EMG:		
❑ Bone Scan:		

5. Treatments so far include:
   - ❑ Physical therapy: _____visits
   - ❑ Exercise program - how long? _____
   - ❑ Chiropractic ❑ Acupuncture
   - ❑ Tens unit ❑ Braces
   - ❑ Anti-inflammatory medications (e.g., Motrin or Naproxen)
   - ❑ Narcotic medications (e.g., Tylenol #3, Vicoden, Darvocet)
   - ❑ Epidural injections: _____ times. How long did they relieve the pain for? _____

E. MEDICATIONS YOU TAKE FOR <u>ALL</u> HEALTH ISSUES: (list dose and frequency): ❑ None

Medication	*Dosage*

F. MEDICATIONS YOU HAVE TRIED FOR YOUR SPINE PROBLEM (list dose and frequency):

Medication	*Dosage*

G. *MEDICATION ALLERGIES:* ❑ None

Medication	*Reaction*			
_____	❑ rash	❑ upset stomach	❑ wheezing or shock	❑ other: _____
_____	❑ rash	❑ upset stomach	❑ wheezing or shock	❑ other: _____
_____	❑ rash	❑ upset stomach	❑ wheezing or shock	❑ other: _____

Iodine Allergy: ❑ ***NO*** ❑ ***YES, describe reaction***

_____

H. YOUR MEDICAL HISTORY (check all that apply): ❑ None apply

❑ Heart attack	❑ Mental Illness	❑ Stomach ulcers
❑ Heart failure	❑ Kidney stones	❑ Liver trouble
❑ High Blood Pressure	❑ Kidney failure	❑ Hepatitis
❑ Osteoarthritis	❑ Cancer	❑ Thyroid trouble
❑ Rheumatoid arthritis	❑ Alcoholism	❑ Bleeding disorder
❑ Ankylosing Spondylitis	❑ Lung disease	❑ Anemia
❑ Gout	❑ AIDS	❑ Serious injury: _____
❑ Osteoporosis	❑ Tuberculosis	❑ Other: _____
❑ Diabetes	❑ Asthma	❑ Other: _____
❑ Stroke	❑ Blood clot in leg	❑ Other: _____

I. SURGICAL HISTORY (including spine):

Operation	*Surgeon/City*	*Date*

J: INJURY HISTORY

1. Do you have a prior history of back or neck problems? _____
2. Any prior industrial or Workers' Compensation claims? ❑ Yes ❑ No Explain:
   _____
   _____

K. SOCIAL HISTORY & HABITS:

1. Work status: ❑ Homemaker ❑ Working ❑ Retired ❑ Disabled ❑ On leave
2. Date last worked: _____
3. Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Co-Habiting
4. I live: ❑ Alone ❑ With: _____
5. Tobacco: ❑ Neve ❑ Cigar ❑ Chew ❑ Pipe ❑ Cigarettes ___pack/day for ___years ❑ Quit, when? _____
6. Alcohol: ❑ Never or rare ❑ Social ❑ Frequently (more than twice a week) ❑ Alcoholic ❑ Recovering
7. Illicit/Street Drug usage: ❑ Never ❑ In the past ❑ Currently ❑ IV Drugs
8. Because of this problem, do you have or plan to have: ❑ Law suit ❑ Workman's Comp Claim ❑ Unsure ❑ None

L. FAMILY HISTORY (list any illnesses that "run" in your family):

_____
_____
_____

M. REVIEW OF SYSTEMS (check all that apply): ❑ None apply

❑ Reading glasses
❑ Change of vision
❑ Loss of hearing
❑ Ear pain
❑ Hoarseness
❑ Nose bleeds
❑ Difficulty swallowing
❑ Morning cough
❑ Shortness of breath
❑ Fever or chills
❑ Heart or chest pains
❑ Abnormal heartbeat
❑ Swollen ankles

❑ Toothache
❑ Gum trouble
❑ Nausea or vomiting
❑ Stomach pain
❑ Ulcers
❑ Frequent belching
❑ Frequent diarrhea
❑ Frequent constipation
❑ Hemorrhoids
❑ Frequent urination
❑ Burning on urination
❑ Difficulty starting urination
Other: _____

❑ Frequent Headaches
❑ Blackouts
❑ Seizures
❑ Frequent rash
❑ Hot or cold spells
❑ Recent weight change
❑ Nervous exhaustion

Women Only:
❑ Irregular periods
❑ Vaginal discharge
❑ Frequent spotting

Other: _____

Is your primary care doctor aware of the above check problems? ❑ YES ❑ NO

N. Approximate height: _____ ***Approximately weight***: _____

O. Indicate the location and description of your pain by placing the appropriate letter symbols on the body diagram below:

TYPE OF PAIN	**SYMBOL**
Aching	AAAA
Burning	BBBB
Numbness	NNNN
Pins & Needles	PPPP
Stabbing	SSSS