

MRN: _____
BP: _____
HR: _____
TEMP: _____

SPINE CENTER QUESTIONNAIRE

I. DEMOGRAPHICS

Name: _____ DOB: _____ Age: _____

SSN: _____ Height: _____ Weight: _____

Referring Physician: _____ Primary Care Physician: _____

Other Treating Physicians: _____

II. PRESENTING PROBLEM(S)

Problem: Neck Back

Please describe your problem: _____

When did your problem begin? _____

III. INJURY

Was there a specific event which caused your problem (Ex. Car accident, fall, etc)? Yes No

If Yes, What? _____

Have you ever had problems in this area before? Yes No

Is this injury work-related? Yes No

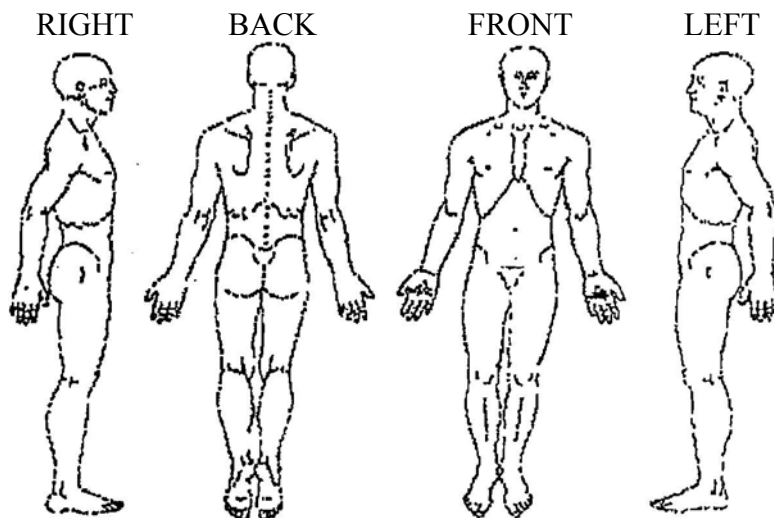
If Yes, did you file a claim through Workers Compensation? Yes No

IV. PAIN

This section is to describe your pain. Numbness will be described in the next section.

Does this problem cause pain? Yes No

If Yes, Please continue and mark your pain on the figures below:



Pain Scale 0-10 (0 = no pain, 10 = worst possible pain)

What number would you give your pain today? _____

What number would you give your pain on average? _____

What number would you give your worst pain? _____

Please check all that describe your pain:

- | | | | |
|--|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Shooting | <input type="checkbox"/> Sharp/Stabbing | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Pulling/Tearing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramping | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Other: _____ | | | |
-

Please check the appropriate descriptions below:

My pain:

- | | | |
|---|--|--|
| <input type="checkbox"/> Began Suddenly | <input type="checkbox"/> Is Constant | <input type="checkbox"/> Began Gradually |
| <input type="checkbox"/> Comes and Goes | <input type="checkbox"/> Interrupts my Sleep | |

My pain is worse:

- | | | | |
|---|--------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> During the Day | <input type="checkbox"/> Night | <input type="checkbox"/> Morning | <input type="checkbox"/> Afternoon |
|---|--------------------------------|----------------------------------|------------------------------------|

My pain is worse:

- | | | | |
|--|----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Lying (Back/Side/Stomach) | |
| <input type="checkbox"/> Frequently Changing Positions | | <input type="checkbox"/> Nothing makes it worse | |
| <input type="checkbox"/> Sports: _____ | | <input type="checkbox"/> Other: _____ | |

My pain is better:

- | | | | |
|--|----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Lying (Back/Side/Stomach) | |
| <input type="checkbox"/> Frequently Changing Positions | | <input type="checkbox"/> Nothing makes it better | |
| <input type="checkbox"/> Sports: _____ | | <input type="checkbox"/> Other: _____ | |

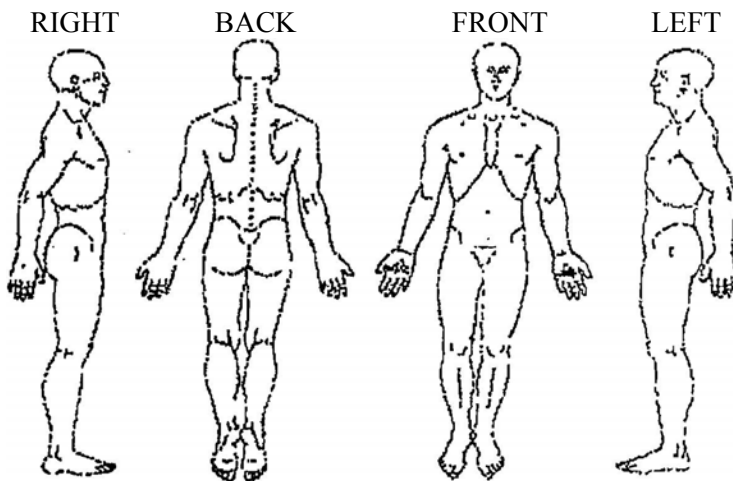
My pain is best described by ONE of the following words:

- | | | | |
|--|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Trivial/Minimal | <input type="checkbox"/> Limiting | <input type="checkbox"/> Disabling | <input type="checkbox"/> Unbearable |
|--|-----------------------------------|------------------------------------|-------------------------------------|
-

V. NUMBNESS/TINGLING

Do you feel numbness or tingling? Yes No

If Yes, Please complete the following and mark your numbness (lack of feeling) or tingling (pins and needles) on the figures below:



My numbness/tingling is made worse by (check all that apply):

- | | | | |
|--|----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Lying (Back/Side/Stomach) | |
| <input type="checkbox"/> Frequently Changing Positions | | <input type="checkbox"/> Nothing makes it worse | |
| <input type="checkbox"/> Other: _____ | | | |

My numbness/tingling is/are made better by (check all that apply):

- | | | | |
|--|----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Running | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Lying (Back/Side/Stomach) | |
| <input type="checkbox"/> Frequently Changing Positions | | <input type="checkbox"/> Nothing makes it better | |
| <input type="checkbox"/> Other: _____ | | | |

VI. SPINAL DEFORMITY

Have you ever been told you have a curve in your spine or scoliosis? Yes No

Please check all that apply:

- I have spinal curvature or deformity present since birth.
- I have spinal curvature or deformity developed in childhood.
- I have spinal curvature or deformity developed as an adult.
- I wore a brace when I was younger for this.
- I currently wear a brace for this.
- I feel my curvature is getting worse.
- I feel that I have lost height.
- I feel my clothes no longer fit properly.

Please check all that apply:

- I have a lump or mass on my spine that is growing larger.
- I have a lump or mass on my spine that is not growing larger.
- I have a lump or mass on my spine that is painful.
- I have a lump or mass on my spine that is not painful.

VII. ASSOCIATED PROBLEMS

Please check all that apply:

I have:

- | | |
|---|--|
| <input type="checkbox"/> Clumsiness in my hands | <input type="checkbox"/> Frequent falling or stumbling |
| <input type="checkbox"/> To look at feet to walk | <input type="checkbox"/> Inability to stand up straight |
| <input type="checkbox"/> Leakage of bowel | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Inability to completely empty bladder. If so, has this been evaluated? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

VIII. TESTING/TREATMENT

Please check the following tests you have had within the past one year for your spine problem:

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> X-Rays | <input type="checkbox"/> CT (CAT Scan) | <input type="checkbox"/> MRI | <input type="checkbox"/> Nerve Study (EMG/NCS) |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Blood Test | <input type="checkbox"/> Bone Density Scan |
| <input type="checkbox"/> I have had no tests to evaluate my problem | <input type="checkbox"/> Other: _____ | | |

Please check if you have been treated by the following and how your problem was affected:

	Complete Relief	Improved	No Change	Worse
Physical Therapy				
Home Exercises				
Chiropractic				
Epidural Steroid Injection				
Facet Joint Injection				
Muscle Injection				
Massage				
Brace				
Acupuncture				
Other:				

I have not had any of the above treatments

Please list medications you have taken for this problem:

Dates Taken	Medication	Dose	Frequency	Helpful?

IX. SPINE HISTORY

Have you had previous surgery on your spine? Yes No

If Yes, Please List:

Date	Procedure	Outcome (Poor/Good/Excellent)