Height: _____
Weight: _____

Spine Questionnaire

Name: _____ Occupation: _____

Name of physician/person who referred you: _____

Chief Complaint (describe any injury/accident): **Date of Injury/ onset:** _____

Was injury work related or related to a motor vehicle accident? Yes __ No __

Do you have more pain in your neck/ lower back or more radiating pain in the arms/ legs? Please circle below:

Neck and arm pain				
neck	75% neck	50% neck	25% neck	0% neck
	25% arm	50% arm	75% arm	100% arm

Lower back and leg pain				
back	75% back	50% back	25% back	0% back
	25% leg	50% leg	75% leg	100% leg

Which leg/ arm is more painful? Left __ Right __

Have you had any of the following?
Bowel/bladder problems? Yes __ No __ If yes, for how long? _____
Arm/leg weakness? Yes __ No __ If yes, for how long? _____
Balance problems? Yes __ No __ If yes, for how long? _____

Please check all that apply:

Pain level/character:	☐none	☐dull	☐occasional pain	☐pain improving
	☐mild	☐sharp	☐constant pain	☐pain worsening
	☐moderate	☐burning	☐pain with activities	☐no change
	☐severe	☐aching	☐pain at night	

Worsens with: ☐sitting ☐standing ☐walking ☐bending ☐lifting
☐Other_____

Improves with ☐sitting ☐standing ☐walking ☐stretching ☐lying down
☐Ice ☐heat other_____

Treatment History:
Have you been treated with physical therapy or epidural blocks for this condition?
Physical therapy:
☐ yes ☐ no If yes, please list dates: _____
☐provided relief ☐ no relief What facility?_____

Epidural Injections:
☐ yes ☐ no
If yes, how many epidurals have you had? _____ which doctor? _____
Please list the dates of your epidural blocks:

Did the epidural blocks provide relief?
☐provided relief ☐ no relief

Have you seen any other doctors for your problem?

Name:_____Date:_____ Name: _____Date:_____

Diagnosis: _____ Diagnosis: _____

Recommendation:_____ Recommendation:_____

Have you had any studies (X-ray, MRI, CT, Bone scan)? List study, facility and date.

Medical Conditions

List any medical conditions current or past, including cardiac and psychiatric (use back of page if necessary):

Spine Surgery History

List all past spine surgeries, physician and dates (use back of page if necessary):

Medication History

Are you currently taking a blood thinner? YES ___ NO __

If yes, which blood thinning medication do you take?

__Aspirin __Eliquis __Plavix __ Coumadin __Lovenox __Pradaxa OTHER: _____

Who is the prescribing doctor for that medication? _____

For what condition is the blood thinner prescribed? _____

Are you currently in pain management?: yes ____ no ____ if yes, physician's name: _____

List all **pain** medications you take including dosage and frequency (use back of page if necessary):

Allergy History

Do you have an allergy to PENICILLIN? YES __ NO __

Do you have an allergy to SULFA Antibiotics? YES __ NO __

List any drug and environmental allergies you have:

Visual Analog Scale

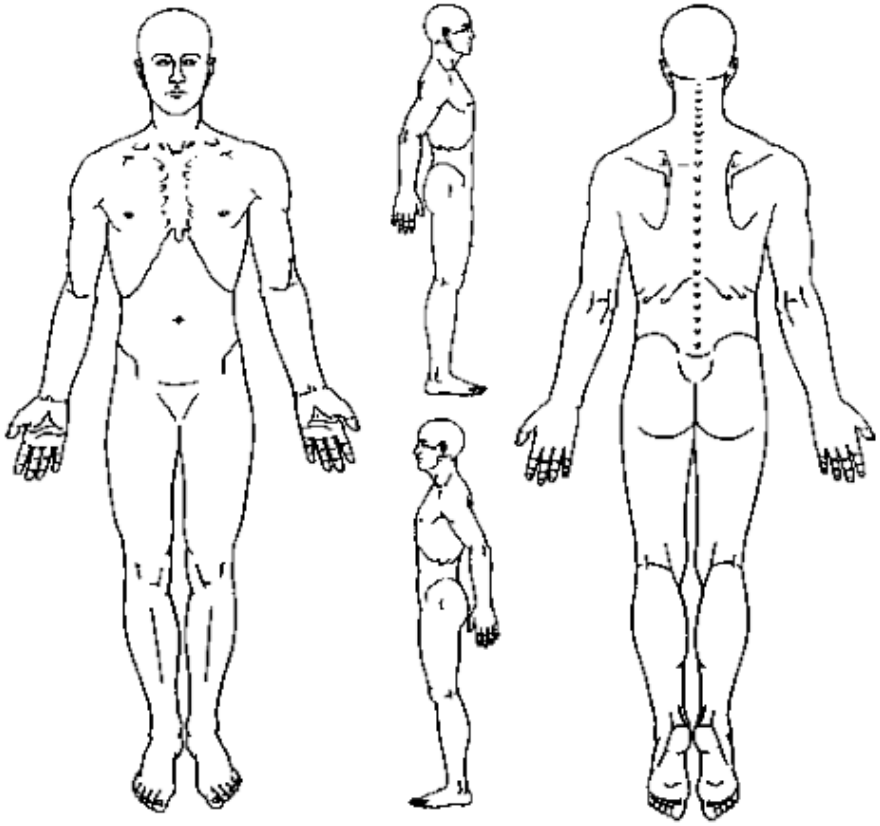
NAME:_____ DATE: _____

Please circle the number that best describes the question being asked.
Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference

1. RIGHT ARM or LEG PAIN
no pain 0____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10____ worst possible pain

2. LEFT ARM or LEG PAIN
no pain 0____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10____ worst possible pain

3. NECK or BACK PAIN
no pain 0____ 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ 8_____ 9_____ 10____ worst possible pain



Please mark on the above diagram where your symptoms are located using the letters below. **

A= ACHE B= BURNING N=NUMBNESS
P= PINS & NEEDLES S= STABBING O= OTHER