



Date of Initial Visit: ____/____/____

Last Name _____ First Name _____

Age: _____ Date of Birth ____/____/____ Sex: _____ Weight: _____ Height: _____

Phone: Home _____ Work _____ Mobile _____

Email: _____

Who referred you to the Spine Institute?

Referring Physician Name _____

Referring Physician Telephone # _____

Referring Physician Address _____

City _____

State _____

Zip Code _____

Please describe your main problem/complaint. _____

PLEASE PUT AN "X" NEXT TO THE BEST ANSWER FOR EACH QUESTION

SOCIAL HISTORY

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Highest Education Level Completed:

___ (0, 1 2 3 4 5 6 7 8) Grade school

___ (9 10 11 12) High school

___ (13 14 15 16) College, Technical

___ (> 16 YEARS) Graduate, Professional

Do you currently use Tobacco? ___ Yes ___ No Started Age/Yr. _____ Stopped Age/Yr. _____

Indicate quantity per day: Cigarettes _____ Cigars _____ Chewing Tobacco _____

Do you currently consume Alcohol? ___ Yes ___ No

Indicate quantity per day: Beer _____ Wine _____ Distilled Spirits _____

WORK STATUS

Occupation _____

Are you currently?

___ Working Full time

___ Working Part time

___ Unemployed

___ Retired

___ Disabled, Temporarily

___ Disabled, Permanently

___ Housewife

___ Other _____

If you are currently NOT working:

How long have you been off work due to your back/neck pain? _____



PAST MEDICAL HISTORY - Check below if you have had any of the following:

- | | | | |
|---|--|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> OTHER _____ | | | |

Current Medications (include Non-Prescription): _____

Medicine / Substance Allergies (include Reaction): _____

CURRENT MEDICAL CONDITION:

Do you have: Only back pain Only leg pain
 Back and leg pain Only neck pain
 Only shoulder pain/arm pain Neck, shoulder and arm pain
 Other _____

Which is worse: Back pain Leg pain
 Neck pain Shoulder/arm pain

I have had back/neck pain: Less than 1 month 1 - 3 Months
 3 - 6 Months 6 Months - 1 Year
 1 - 3 Years 3 - 5 Years
 Greater than 5 years

My pain came on: Gradually, over time Quickly

My pain was brought on by: No specific incident
 Following an accident or incident at work
 Following an accident or incident NOT at work

Describe the accident/incident: _____

Do you have: NUMBNESS Where _____
 TINGLING Where _____
 WEAKNESS Where _____

What time of the day is your pain worse: Morning Late in the day The middle of the night

My pain pattern is: A Single attack of pain Attacks of pain with pain free intervals
 Continuous pain Continuous pain with attacks of severe pain

I experience pain: The entire day
 Most of the day (16-20 HOURS)
 A Good part of the day (8-15 HOURS)
 A Fair amount of the day (2-7 HOURS)
 A Small amount of the day (1 HOUR OR LESS)
 Less than once per day



How long does a pain attack last: _____ Seconds _____ Minutes _____ Hours _____
Constant

For how long can you walk: _____ Less than 15 minutes _____ 15 - 30 Minutes
_____ 30 - 60 Minutes _____ NO Restrictions

How long can you sit: _____ Less than 15 minutes _____ 15 - 30 Minutes
_____ 30 - 60 Minutes _____ NO Restrictions

How long can you stand: _____ Less than 15 minutes _____ 15 - 30 Minutes
_____ 30 - 60 Minutes _____ NO Restrictions

What position/activity make the pain worse or better?

	Better	Worse	Comments		Better	Worse	Comments
Standing				Bending			
Sitting				Lifting			
Walking				Coughing			
Stairs				General Activity			
Lying Down				Bowel Movement			

Pain Rating Scale: How would you rate your pain today: (Circle One Number)

No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst Possible Pain
None Mild Moderate Severe

Where have you sought help for your pain: (Check all that apply)

Family Doctor Physical Therapist Physiatrist
 Orthopedic Doctor Neurologist Chiropractor
 Spine Surgeon Psychiatrist / Psychologist Pain Clinic
 OTHER _____

Have any of the above decreased your pain: _____ NO _____ YES Specify _____

My pain now seems to be: _____ Getting better _____ Staying the same _____ Getting worse

Have you noticed any change in your bowel or bladder habits:

_____ NO _____ YES Describe: _____

Have you had previous Surgery:

_____ YES WHEN: ____/____/____ TYPE: _____
 _____ NO WHEN: ____/____/____ TYPE: _____
 WHEN: ____/____/____ TYPE: _____

If you had previous spine surgery, did the surgery make the pain better: _____ YES _____ NO

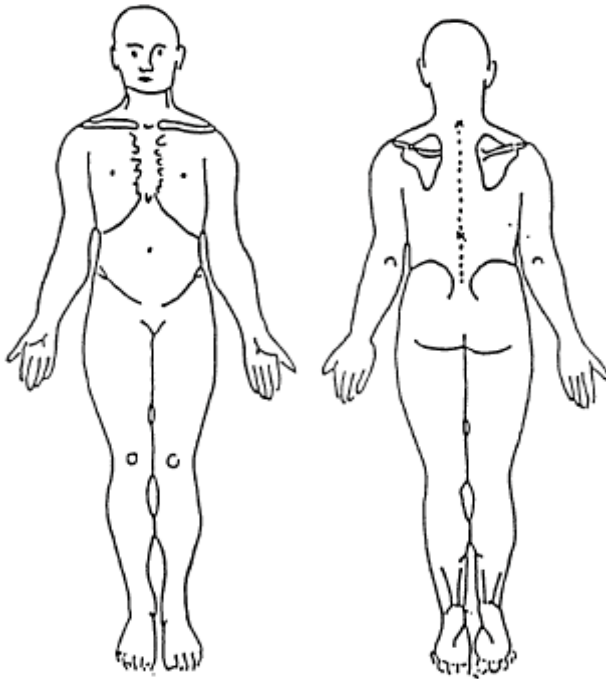
Have you, or are you planning to apply for disability or workmen's compensation: _____ YES _____ NO

Is there a lawsuit or litigation pending in relationship to your pain? _____ YES _____ NO

- - FOR OFFICE USE ONLY - -

Patient/Family Education Record:

Learner: π Patient π Family π Other _____ **Learning Needs:** πTreatments π Medications π Disease Process π Pain π Other _____
Barriers: π None π Physical π Language π Cultural/Religious π Financial π Cognitive π Psychosocial
Methods: πDiscussion π Demonstration π Handout π Other _____ **Follow Up Plan:** π Review π Other _____
Comprehension: πVerbalized Understanding πReturn Demonstration π Other _____ **Signature:** _____



PAIN DIAGRAM:

Please use the following diagrams to show us where you are experiencing pain and numbness:

Pain: x x x x x x

Numbness: o o o o o o o

Aching: / / / / / /

Please circle all of the following adjectives which describe your pain:

- DULL
- BURNING
- COLD
- SHOOTING
- TIGHT
- THROBBING
- ELECTRIC
- TINGLING
- OTHER _____

Patients with Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS / KYPHOSIS SECTION

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis/ Kyphosis: None Parent
 Brother/ Sister Cousin
 Other _____

Previous non-operative treatment: None Exercise
 Brace Observation only
 Other _____

First operative event: ____/____/____ Second operative event: ____/____/____

Current concerns: None Feel imbalance
 New or increased back pain Painful rod
 Unhappy with my appearance

If you have back pain, then where: Upper back Mid back Lower back

Do you feel that your curves have increased or decreased over time: Yes No

Do you feel you have lost height in the last few years: Yes No

*** END OF QUESTIONNAIRE ***