ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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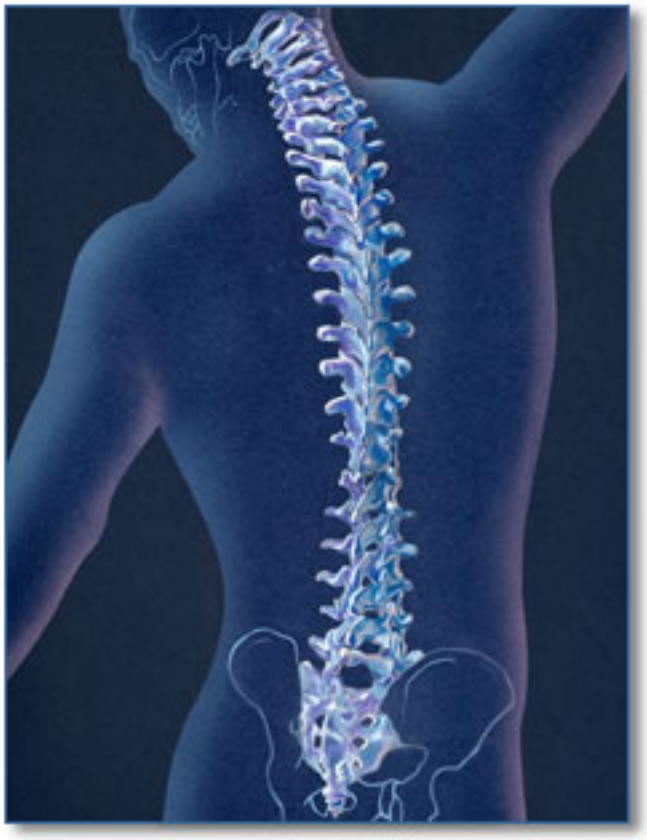
Spine Pain Questionnaire



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Today Date:_____

Name:_____Age:_____ Date of birth:_____

Who referred you to our office?:_____

What problem do you have with your neck or back? _____

_____

When did your problem start? _____

INJURY OR TRAUMA (Section A)

Did a particular accident or injury cause your problem? □ No (please **skip** to Section B)

□ Yes (continue this section)

Check only one:

□ I never had back/neck problems in this area of my spine before this injury.

□ I had back/neck problems in this area of my spine before, and this injury made the problem worse.

Check all that apply:

□ This injury occurred at work.

□ This injury did not occur at work.

□ I have filed a claim through workers compensation.

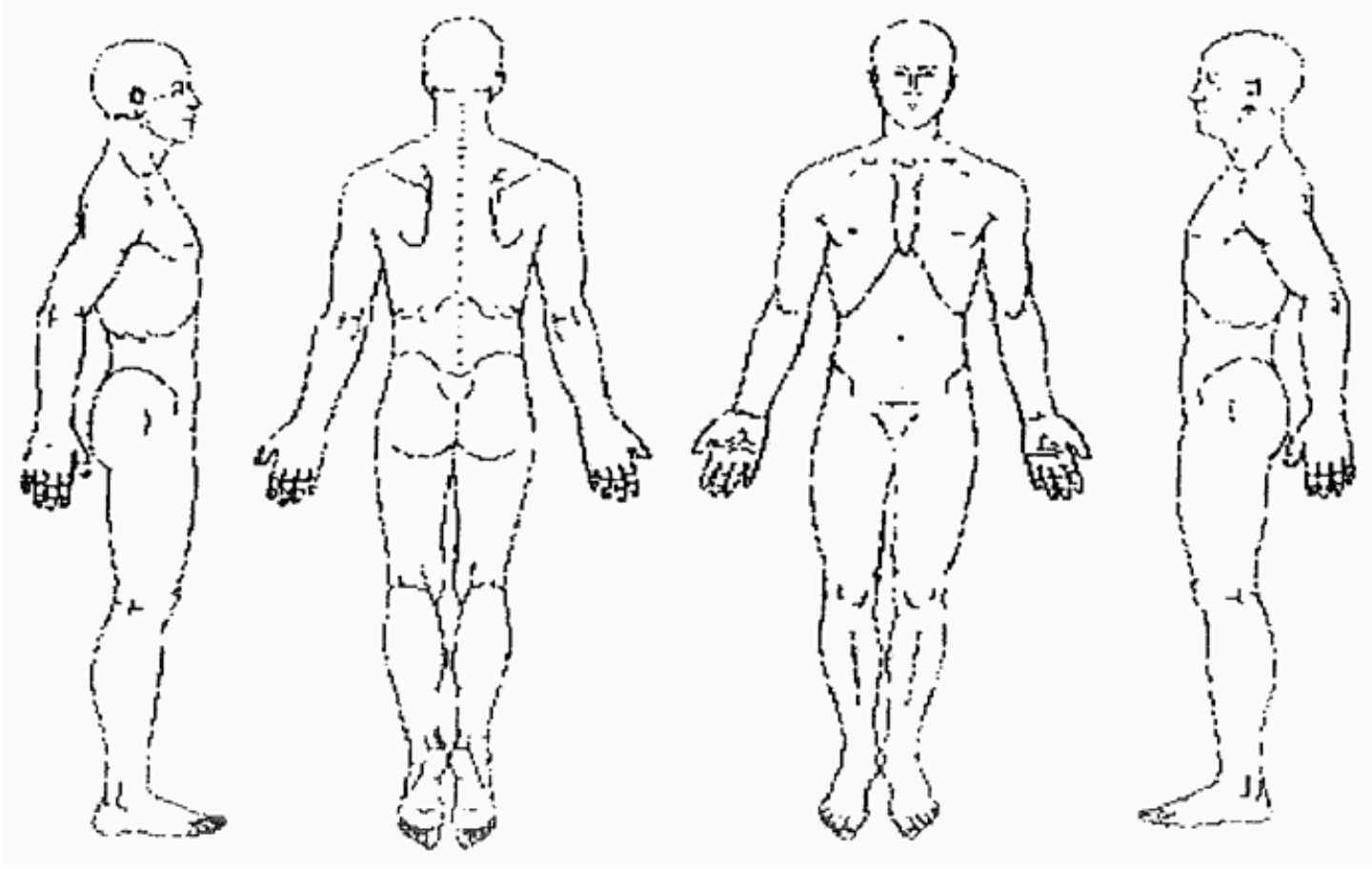
PAIN AND DISABILITY: (Section B)

This section pertains to pain **only**. You will have an opportunity to answer questions about numbness and tingling in **section C**.

Does your neck or back problem cause pain? □ No (please **skip** to section C)

□ Yes (Continue this section) Mark your **pain** on the fig below.

RIGHT BACK FRONT LEFT



Pain scale 0-10 (0= No pain, 10= pain severe enough to pass out)

What number would you give your pain today? _____

What number would you give your pain on average? _____

What number would you give your pain at its worse? _____

Please check all that describe your pain:

□ Burning □ Sharp/Stabbing □ Tingling □ Aching □ Throbbing

□ Shooting □ Pulling/Tearing □ Cramping □ Other:_____

Please check all of the appropriate responses in each category to complete the phrase

My pain…

□ began suddenly □ began gradually □ interrupts my sleep

□ is constant □ comes and goes

My pain is worse…….

□ during the day □ at night □ in the AM □ in the afternoon

My pain is worse when……..…..

□ Walking □ Running □ Standing □ Sitting □ Bending □ lifting □ driving

□ applying heat □ applying ice □ exercising □ Frequently changing positions □ Lying

□ sports (list)_____ □ Over head activity □ **Nothing makes my pain worse**

My pain is better while…….……

□ Walking □ Running □ Standing □ Sitting □ Bending □ lifting □ driving

□ applying heat □ applying ice □ exercising □ Frequently changing positions □ Over head activity

□ Lying on Back □ Lying on Side □ Lying on Stomach □ Recliner □ sports (list)_____

□ **Nothing makes my pain better**

Overall, which single word or phrase would you use to describe your pain the majority of the time?

□ Trivial/Minimal □ Annoying □ Limiting □ Disabling □ Unbearable

Because of my pain, I am unable to…….

□ Walk over _____miles □ Run over _____miles □ Sit longer than _____min/hours

□ Stand longer than _____min/hrs □ Lift over _____lbs

NUMBNESS/TINGLING (Section C)

This section pertains to numbness/tingling **only**. Questions about pain are in the previous section (**section B)**.

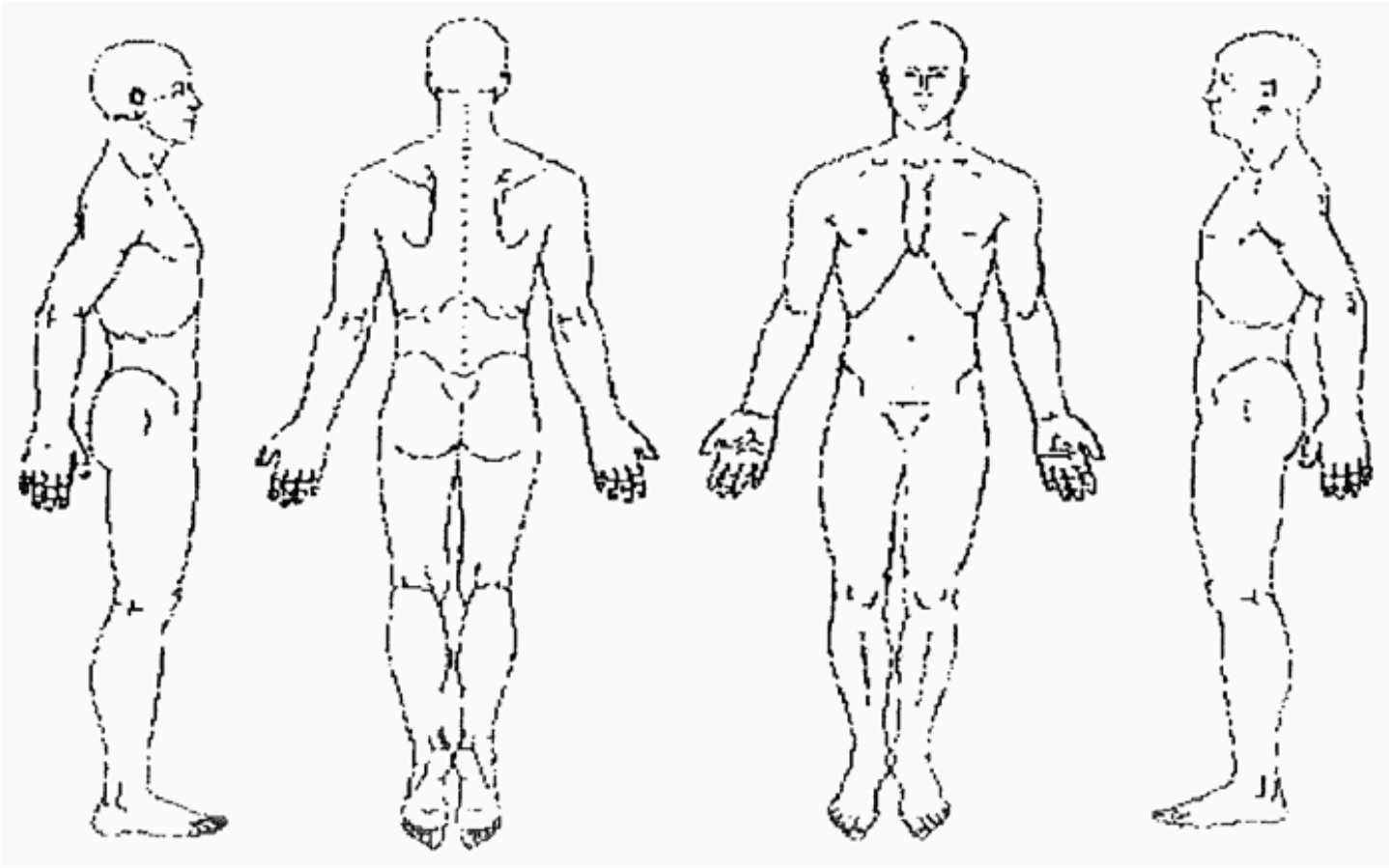
Do you feel numbness or tingling?

□ No (please **skip** to section D)

□ Yes (continue this section)

Please mark on the figure below to show where you feel **numbness** (loss of feeling) or **tingling** (pins and needles).

RIGHT BACK FRONT LEFT



My numbness and tingling is made worse while……

□ Walking □ Running □ Standing □ Sitting □ Bending □ lifting □ driving

□ heat □ Ice □ exercising □ Frequently change of position

□ sports (list)_____ □ **Nothing makes my pain worse**

My numbness and tingling is made better while…….

□ Walking □ Running □ Standing □ Sitting □ Bending □ lifting □ driving

□ heat □ Ice □ exercising □ Frequently change of position

□ sports (list)_____ □ Nothing makes my pain better

SPINAL DEFORMITY/TUMOR (Section D)

Do you have a curve, lump, or mass near or on your spine? □ No (please **skip** to section E)

□ Yes (complete this section)

Please check all that apply to your situation.

□ I have a spinal curvature or deformity (scoliosis or kyphosis) that **was present at birth**.

□ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed in childhood**, and

was not present or obvious at birth.

□ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed as an adult**, and was not present in childhood.

□ I wore a brace when I was younger to help my scoliosis or kyphosis.

□ I am wearing a brace now.

□ I have noticed my spinal curvature getting worse

□ My clothes no longer fit or hang properly

□ I have a lump or mass on my spine that is **getting larger**

□ I have a lump or mass on my spine that is **not getting larger**

□ The mass is painful

□ The mass is **not** painful

ASSOCIATED PROBLEMS (Section E)

Please check all that apply to you

□ Clumsiness in hands. □ Frequent falling or stumbling

□ Must look at feet in order to walk □ Unable to stand up straight

□ Leakage of bowel contents or staining underwear □ Leakage of Urine or staining underwear

□ Unable to completely empty your bladder □ Impotence

□ Unable to look forward without bending knees

□ **I HAVE NONE OF THE ABOVE PROBLEMS**

TESTING AND TREATMENT (Section F)

Which of the following tests have you had in the last year for your spine problem? (check all that apply)

□ X-Rays □ Blood test □ Myelogram □ MRI □ CT (CAT Scan)

□ Discogram □ Bone Density scan □ Nuclear Bone Scan □ Nerve Study (EMG/NCS)

□ Other _____

□ **I HAVE HAD NO TESTS TO EVALUATE MY PROBLEM**

Your treatment history (Please check all that apply)

- Complete relief
- Improved
- Unchanged
- worse
- Physical Therapy

- Home exercises
- Chiropractic
- Epidural Steroid Injection (performed in the Hospital)
- Facet Joint injection (performed in the Hosp)
- Local or Trigger point injection (performed in the office)
- Massage
- Brace, corset, or other support
- Acupuncture
- Other

I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS

Please list all medication you have tried, the dose, and the number of pills used per day for this problem.

(**examples** = naproxen, voltaren, ibuprofen, vicodin, percocet, oxycontin, darvocet, morphine, soma, flexeril, robaxin, baclofen, celebrex, vioxx, bextra. etc)

When last used?

Medication

Dose

Number of pills per day

Did the medication help?

PRIOR SPINE SURGERY (Section G)

Have you ever had surgery on your spine? □ No (please skip to medical history)

(This includes Fusions, decompressions, or any disc procedures)

□ Yes (complete this section)

Date

Procedure

Rate the outcome of surgery Poor, good or excellent (See Legend below)

Legend: Poor = the surgery had no change or made me worse

Good = the surgery improved my symptoms

Excellent = Dramatically improved or resolved my symptoms

General Medical Section

MEDICAL HISTORY

Please check or circle any medical problem you currently have, or have experienced in the past.

- Diabetes(Sugar)
- Seizures
- Hypertension (high blood pressure)
- Stroke or Aneurysm
- Heart Disease
- Emphysema/COPD
- Hepatitis
- Kidney/Bladder problems
- Asthma
- HIV/AIDS
- Blood Clotting Problems
- Other Joint Pain
- Tuberculosis
- Valley Fever (coccidiomycosis)
- Reflux Disease
- Hiatal Hernia
- Stomach Ulcers
- Anemia
- Rheumatoid Arthritis
- Cancer (type):_____
- Depression **before** spine surgery
- Depression **after** spine surgery
- Psychiatric illness:_____
-

I have not had any medical problems

Other:

What medications do you take for problems UNRELATED to your spine?

Medication

Dose

Please list all non-spine related surgeries:

Procedure

Date (month/year)

Please list all the Doctors you have seen in the last 2 years:

Doctor

Issue or Problem

MEDICATION ALLERGIES

□ I do not know of any allergies or reactions to any medication

□ I am allergic to:

- Sulfa
- Codeine
- Penicillin (PCN)
- Latex
- Contrast Dye
- Shellfish
- Other medication reactions: (Please use other side if necessary)

Medication

Reaction

FAMILY HISTORY

Please check next to any medical problem that runs in your family.

- Diabetes
- Seizures
- Hypertension (high blood pressure)
- Stroke or Aneurysm
- Heart Disease
- Emphysema/COPD
- Hepatitis
- Kidney/Bladder problems
- Asthma
- Tuberculosis
- Valley Fever (coccidiomycosis)
- Stomach Ulcers or Reflux disease (Peptic ulcer, hiatal hernia, etc)
- Osteoarthritis (Degenerative

- Rheumatoid Arthritis
- Cancer (type):_____
- Depression **before** spine surgery
- Depression **after** spine surgery
- Psychiatric illness:_____
- **I have not had any medical problems**
- Other:
-

SOCIAL HISTORY

What is your current occupation?_____

How long? _____

Please check all that apply to your work or school status:

□ I have missed no time from work or school because of my spine problem

□ I am currently working full time

□ I have missed a total of _____ days from work or school because of my spine problem.

□ I am working

- Part time
- Limited duty

□ I am unable to work at all because of my spinal problem

□ I am unable to work at all because of another problem not related to my spine (diagnosis)

_____

□ The last date I worked was: _____

□ I have been receiving worker's compensation since _____

□ I have been on disability since _____

What is your marital status?

- Single
- Married
- Separated
- Divorced
- Widowed

What is your living situation?

- Homeless
- with children
- with spouse
- with relatives
- Alone

List your recreations or sports with frequency and duration.

_____

_____

_____

_____

_____

Please check all that apply to you:

□ I never smoked cigarettes

□ I quit smoking _____years/months ago

□ I smoke cigarettes at _____packs per day

□ I have smoked for _____years

□ I chew tobacco

□ I never drink alcohol

□ I drink alcohol

Very often

Daily

Weekly

Monthly

rarely

□ I am recovering from a drinking problem

□ Recreational drug use

□ I have not, nor do I plan to take legal action related to this injury.

□ I am considering or have taken legal action as a result of this injury.

□ Legal action related to this injury is closed or settled.

REVIEW OF SYSTEMS

Please check all problems below that apply to you.

- Shortness of Breath
- Nausea and Vomiting
- Fever
- Chest Pain
- Fainting
- Chills
- Memory problems
- Loss of Consciousness
- Night Sweats

- Anxiety or Nervousness
- Dizziness
- Bowel Incontinence
- Chronic Fatigue
- Convulsions
- Unable to Urinate
- Frequent Headaches
- Unexplained Weight Loss
- Loss of Appetite

Thank you for completing the questionnaire. It will be incorporated into your initial evaluation.