Davis Spine & Orthopaedics

Spine and Orthopaedic Surgeon
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Spine Questionnaire

Today's Date________________

Please take the time to complete all of this form. Your careful, accurate, complete, and legible answers will help us to understand your presenting problem and help us design the best treatment program for you.

Name ___________________________________ SS# ________________ Date of Birth _________ age: _____
Last First M.I.
Home #_______________________ Work #_________________________Cell # ________________________
Emergency Contact Name & number ____
Occupation ______________________Employer _____________________ Address______________________

Referring Physician____________________________ Phone ____________Address_____________________
Primary Care Physician__________________________ Phone ____________Address_____________________
Other Physician(s)_____________________________ Phone ____________Address_____________________

Are you currently working? □ Yes □ No If yes, then how many hours per week? _____________
Is your job □ sedentary □light □ medium □ heavy?
If you are not currently employed, indicate how long you have been off work; ___________________________

Do you currently smoke? □ Yes □ No
If Yes, and how many packs per day? ____________________________
Do you consume alcoholic beverages (Include quantity and frequency)? ________________________________
Is there a history of low back pain, arthritis, headaches or other major chronic illness that runs in your family?
____

Are you: □ Right □ Left Handed
Sex: □ Male □ Female
Are you: □ Single □ Married □ Widowed □ Separated □ Divorced

What is the **main** problem(s) for which you are seeking treatment?_____________________________________
____

Are you currently in pain management? □ Yes □ No
If yes, where? ____

Height ____________________ Weight ____________________

When did your current problem start? _______/_______/_________ (month/day/year)
Have you ever had similar problems before? □ yes □ no
Did your symptoms start: □ suddenly □ gradually

Please indicate how your present symptoms **began**?

- ☐ during an athletic activity
- ☐ while lifting
- ☐ while bending
- ☐ unknown
- ☐ while seated
- ☐ as a result of an auto accident
- ☐ while working
- ☐ other ____________________

Please indicate where your pain/symptom was **initially** located:

- ☐ neck
- ☐ low back
- ☐ neck and arms
- ☐ mid back
- ☐ low back and legs
- ☐ unknown
- ☐ other ____

Please check the most appropriate statement: my symptoms

- ☐ have remained the same since the time of injury;
- ☐ are more severe since the time of injury;
- ☐ are less severe since the time of injury;

How have the symptoms of your pain **changed**?

- ☐they are unchanged
- ☐increased aggravation in one arm or leg;
- ☐increased aggravation in both arms or legs;
- ☐increased aggravation in the back or neck;
- ☐ increased aggravation in both arms/legs and back/neck

Which of the following best describes your pain ratio?

- ☐100% back/neck pain;
- ☐75% back/neck pain and 25% leg/arm pain;
- ☐50% back/neck pain and 50% leg/arm pain;
- ☐25% back/neck pain and 75% leg/arm pain;
- ☐ 100% leg/arm pain

You have already provided us with Information about your present pain please give us the approximate dates of any **other** episodes of back /neck pain:

Episode A ______/______ / ____________ ____

Episode B ______/______ / ____________ ____

Is your **current** pain (please check one)?

- ☐constant
- ☐ intermittent and occurring on most days
- ☐intermittent and occurring daily
- ☐infrequent

How would you describe the pain (choose **as many** adjectives as are applicable)?

- ☐burning
- ☐pins/needles
- ☐numb
- ☐ aching
- ☐throbbing
- ☐sharp
- ☐shooting
- ☐tearing
- ☐ gnawing
- ☐miserable
- ☐electric-like
- ☐stabbing
- ☐penetrating
- ☐dull
- ☐other____

PAIN LOCATION (Please mark the location(s) of your pain on the diagrams below)

Front

Back

PAIN SEVERITY **Circle your average level of pain**

Over the last month: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Circle your current pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

RELIEVING AND AGGRAVATING FACTORS

How do the following affect your pain? (Check one for each tern)

	Decrease	No Change	Increase
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Rising from sitting	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying on your back	☐	☐	☐
Lying on your side	☐	☐	☐
Lying on your stomach	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐

Approximate amount of time you can perform the following activities:

	unable	15 min	30 min	45 min	1 hour	indefinitely
Sit	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐

PAST MEDICATIONS

Using the list below indicate the prescription medications that you have tried in the past for your present problem. Please tell us the dosage and number of pills you took of this medication per day.

Opioids
- Tylenol with codeine
- Darvocet (Propoxyphene)
- Percocet
- Vicodin
- Dilaudid (Hydromorphone)
- Oxycontin
- MS Contin
- Methadone
- Duragesic (Fentanyl) patch
- Butrans patch
- Demerol (Meperidine)
- Kadian

Antispasmodics
- Flexeril (Cyclobenzaprine)
- Soma (Carisoprodol)
- Baclofen (Lioresal)
- Zanaflex (TIzanldlne)
- Norflex (Orphenadrine)
- Robaxin (Methocarbamol)

Anti-inflammatories (NSAIDS)
- Ibuprofen (Motrin, Advil)
- Naprosyn (Naproxen)
- Aleve (Naproxen)
- Aspirin
- Lodine (Etodotac)
- Relafen (Nabumetone)
- Feldene (Piroxkam)
- Indomethacin (Indodn)
- Toradol (Ketorotec)
- Mobic (Meloxicam)
- Celebrex (Celecoxib)
- Steroids (Prednisone, Cortisone, etc)

Antianxiety
- Ativan (Lorezapam)
- Klonopin (Clonazepam)
- Valium (Diazepam)
- Xanax (Alprazolam)
- Serax (Oxazepam)
- Halcion (Triazolam)
- Buspar (Busplrone)

Antidepressants
- Elavil (Amitriptyllne)
- Pamelor (Nortriptyline)
- Norpramin (Desipramine)
- Sinequan (Doxepin)
- Trazodone (Desyrel)
- Zoloft (Sertraline)
- Prozac (Fluoxetine)
- Paxil (Paroxetine)
- Wellbutrin (Bupropion)
- Effexor (Venlafaxine)
- Serzone (Nefazodone)

Others
- Neurontin (Gabapentin)
- Lyrica
- Ultram (Tramadol)
- Ambien (Zolpidem)
- Topomax (Topiramate)
- Tegretol (Carbamezapine)
- Dilantin (Phenytoin)
- Lamictal (Lamotrigine)
- Blood thinners

CURRENT MEDICATIONS (please fill out the dosages and how often taken):

_______________________ _______________________ _______________________ _______________________
_______________________ _______________________ _______________________ _______________________
_______________________ _______________________ _______________________ _______________________

ALLERGIES

Please indicate the names of any products (latex, tape, etc); foods (peanuts, etc); medications that you are allergic to (and what happened to you?):

____

Please check all of the treatments you have tried for your pain and then complete the appropriate column:

Treatment	Date (approx.)	No Relief	Moderate Relief	Excellent Relief
☐ Physical Therapy		☐	☐	☐
☐ Occupational Therapy		☐	☐	☐
☐ Aqua Therapy		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Heat		☐	☐	☐
☐ Ice		☐	☐	☐
☐ Traction		☐	☐	☐
☐ Injection (epidural, facet, etc)		☐	☐	☐
☐TENS		☐	☐	☐
☐ Ultrasound		☐	☐	☐
☐ Brace or Collar		☐	☐	☐
☐ Massage		☐	☐	☐
☐ Meditation		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ Other		☐	☐	☐

Please list below all of the **surgeries** that you have had indicate the approximate date and type of operations:

Laminectornies/ discectomies:____

Fusions:____

Other surgeries: ____

For spine surgeries, where was your surgery (hospital name) and who was your surgeon?

____

Did you **improve** from your surgical procedure(s)?

First procedure ☐ Yes ☐No

Second procedure ☐Yes ☐No

Third procedure ☐Yes ☐No

Please list all the diagnostic studies that you have had for this problem (indicate date and results):

MRI ____/_____/____ ____

CT ____/____/____ ____

X-Rays ____/___/____ ____

Discogram ___/___/____ ____

Myelogram ____/___/____ ____

EMG/NCS ____/___/____ ____

Bone Scan ___/___/____ ____

Please check all that apply to you:

- ☐ recent infections
- ☐ **fever or chills**
- ☐ arm numbness
- ☐ leg numbness
- ☐ **bowel accidents/incontinence**
- ☐ **weight loss**
- ☐ genital numbness
- ☐ **bladder accidents/incontinence**
- ☐ severe **nighttime** pain
- ☐ muscle weakness
- ☐ anemia
- ☐ murmur
- ☐ headaches
- ☐ cold hands/feet
- ☐ palpitations
- ☐ hoarse voice
- ☐ leg swelling
- ☐ asthma
- ☐ chest pain
- ☐ double vision
- ☐ cough
- ☐ **cough blood**
- ☐ shortness of breath
- ☐ loss of vision
- ☐ ringing In ears
- ☐ ulcer
- ☐ kidney infection
- ☐ arthritis
- ☐ dry eyes
- ☐ excess sweating
- ☐ menopause
- ☐ pain on urination
- ☐ kidney stones
- ☐ red joints
- ☐ cold intolerance
- ☐ **blood** in **stool**
- ☐ **blood** in **urine**
- ☐ a swollen joints
- ☐ gout
- ☐ diarrhea
- ☐ nausea
- ☐ abdominal pain
- ☐ black stool
- ☐ muscle aches
- ☐ thyroid problem
- ☐ osteoporosis
- ☐ eczema
- ☐ psoriasis
- ☐ dizziness
- ☐ feeling **depressed**
- ☐ rash

Have you experienced significant **stress** this past year? Please explain:

____

Have you had any of the following health problems? Please check all that apply?

- ☐ High blood pressure
- ☐ Diabetes or high blood sugar
- ☐ Kidney disease
- ☐ Heart disease
- ☐ Sleep apnea
- ☐ Liver disease
- ☐ Asthma or wheezing
- ☐ Seizure or epilepsy
- ☐ Bleeding problems
- ☐ Hepatitis
- ☐ HIV
- ☐ Addiction to drugs/alcohol

☐ Cancer; please specify ______________________ ☐ Other; please specify ________________________________