Davis Spine & Orthopaedics

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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: _____
Height _____ Weight _____

Are you currently working? □ Yes □ No If yes, then how many hours per week? _____
Occupation _____Employer _____
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, or other major chronic illness that runs in your family? (please state)
_____

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? _____

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 seated
□ while lifting □ as a result of an auto accident
□ while bending □ while working
□ unknown □ other _____

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

□ neck □ mid back
□ low back □ low back and legs
□ neck and arms □ 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
□decreased aggravation
□please describe: _____

THIS QUESTION IS FOR SPINE PATIENTS ONLY:
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

Have you had any prior injuries/trauma/car accidents? Please give the dates and a brief description.
Episode A _____/_____ / _____ _____
Episode B _____/_____ / _____ _____

Is your **current** pain (please check one)?
□constant □intermittent and occurring daily □ intermittent and occurring on most days □infrequent

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

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

□other_____

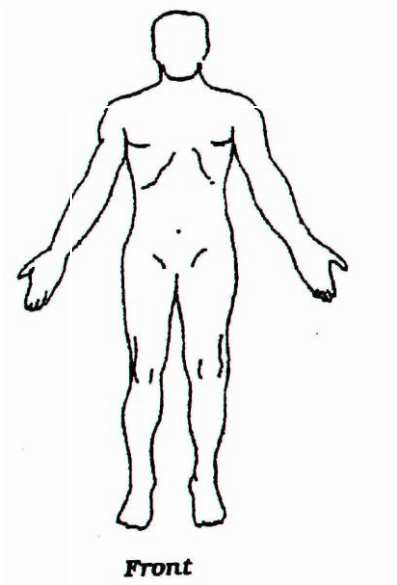
Circle your average level of pain (please label body parts if more than one)
Body part: _____
Over the last month: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Circle your current pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

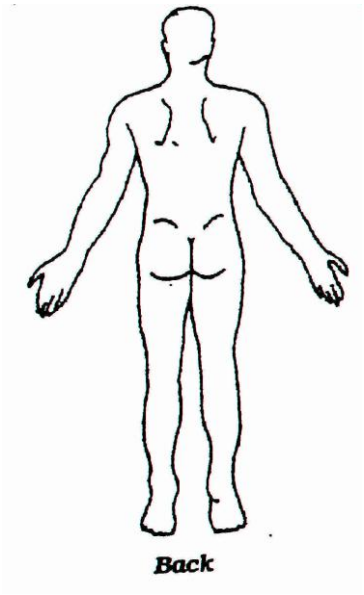
Body part: _____
Over the last month: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)
Circle your current pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Body part: _____
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)

Body part: _____
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)

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





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	☐	☐	☐
Lifting	☐	☐	☐
Carrying	☐	☐	☐
Overhead lifting	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

Approximate amount of time you can perform the following activities:

	unable	15 min	30 min	45 min	1 hour	indefinitely
Sit	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

PAST MEDICATIONS
Using the list below indicate the prescription medications that you have tried in the past for your present problem.

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):

Medication:	Dosage:	Instructions:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.)	Length of treatment	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)? □ Yes □No

Have you had any of the following tests for the current problem?
□ MRI □ CT □ X-Rays □ Discogram □ Myelogram □ EMG/NCS □ Bone Scan

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 □ Asthma or wheezing □ Liver disease □ Hepatitis
□ Seizure or epilepsy □ Addiction to drugs/alcohol □ HIV □ Bleeding problems
□ Cancer; please specify _____ □ Other; please specify _____

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

_____

Please check all that apply to you:

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