

PAIN, NUMBNESS, AND DISABILITY: (Section B)

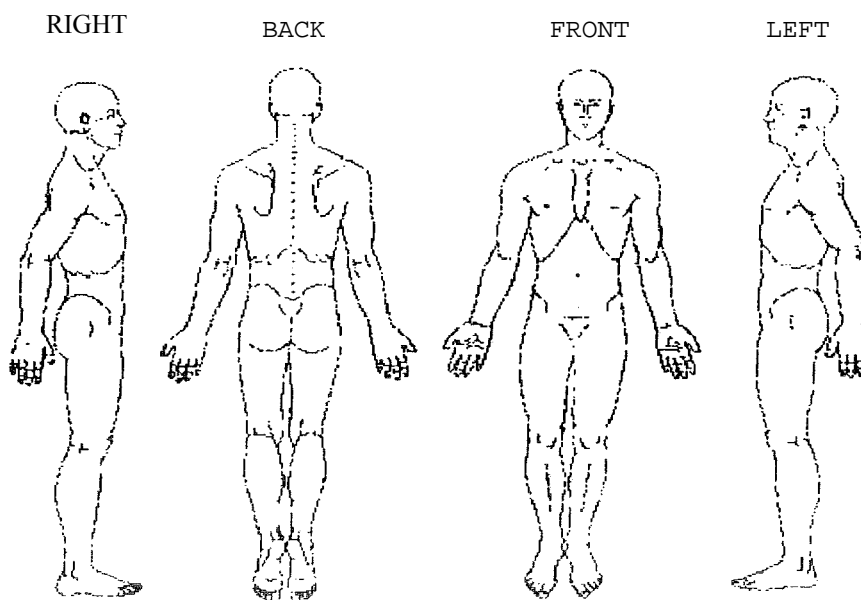
This section pertains to **pain or Numbness**.

Does your neck or back problem cause pain? No
 Yes (Continue this section) Mark your **pain** on the fig below.

Do you feel numbness or tingling? **No (please skip to section C)**
 Yes (continue this section) Mark your numbness below

Please mark on the figure below to show where you feel **pain** using a **X** mark.

Please mark on the figure below to show where you feel **Numbness** using a **#** mark.



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/hrs (circle one)
- Stand longer than _____ min/hrs (circle one) Lift over _____ lbs

SPINAL DEFORMITY/TUMOR (Section C)

Do you have a curve, lump, or mass near or on your spine?

- No (please **skip** to section D)
- 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 D)

Please check all that apply to you

- Clumsiness in hands
- Must look at feet in order to walk
- Leakage of bowel contents or staining underwear
- Unable to completely empty your bladder
- Unable to look forward without bending knees
- I HAVE NONE OF THE ABOVE PROBLEMS**
- Frequent falling or stumbling
- Unable to stand up straight
- Leakage of Urine or staining underwear
- Impotence

TESTING AND TREATMENT (Section E)

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 **RELATED ONLY FOR YOUR SPINE**, 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? |
|-----------------|-----------------|--------|-------------------------|--------------------------|
| mm/yy | Example: Motrin | 800 mg | 4 | Very helpful |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

PRIOR SPINE SURGERY (Section F)

- 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

(Complete all areas below)

MEDICAL HISTORY

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

| | | | | | |
|---|--------------------|---|-------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | Diabetes(Sugar) | <input type="checkbox"/> | Heart Arrhythmia | <input type="checkbox"/> | Hypertension (high blood pressure) |
| <input type="checkbox"/> | Stroke or Aneurysm | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | Emphysema/COPD/Asthma |
| <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | Heart Block | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | Seizures | <input type="checkbox"/> | Other Heart Disease | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | Blood Clotting Problems | <input type="checkbox"/> | Kidney/Bladder problems |
| <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | Hiatal Hernia | <input type="checkbox"/> | Stomach Ulcers |
| <input type="checkbox"/> | Other Joint Pain | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | Reflux Disease |
| <input type="checkbox"/> | Depression | <input type="checkbox"/> Psychiatric illness: | | | |
| Cancer (type): | | | | | |
| <input type="checkbox"/> No medical problems | | Other: | | | |

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

| Medication | Medication |
|------------|------------|
| | |
| | |
| | |
| | |
| | |

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 (Please circle and give reaction below:

| | | | | | |
|-------|---------|------------------|-------|--------------|-----------|
| Sulfa | Codeine | Penicillin (PCN) | Latex | Contrast Dye | Shellfish |
|-------|---------|------------------|-------|--------------|-----------|

(Please use other side if necessary)

| Medication | Reaction |
|------------|----------|
| | |
| | |
| | |

FAMILY HISTORY

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

| | | |
|--|--|---|
| <input type="checkbox"/> Diabetes(Sugar) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Stroke or Aneurysm | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Valley Fever (coccidiomycosis) | <input type="checkbox"/> Stomach Ulcers or Reflux disease (Peptic ulcer, hiatal hernia, etc) |
| <input type="checkbox"/> Osteoarthritis (Degenerative) | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cancer (type): _____ |
| <input type="checkbox"/> Depression | | <input type="checkbox"/> Psychiatric illness: _____ |
| <input type="checkbox"/> There are no medical problems in my family | <input type="checkbox"/> 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.

| | | |
|---|--|---|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea and Vomiting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Anxiety or Nervousness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bowel Incontinence (Uncontrolled defecation) |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Unable to Urinate |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Loss of Appetite |

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

The End