BERMUDA SPINE CENTER
NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Name: _____Age: _____ Date of birth: _____

Who referred you to our office? _____

When did your problem start? _____

Instructions: Only complete sections A-G below that apply to you. There will be a General Medical section that will need to be completed in full and starts on page 6.

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.

☐ I have filed a claim through workers compensation.

DO NOT WRITE BELOW THIS LINE. (Continue questionnaire on page 2)

Charities House, Ground Floor, 25 Point Finger Rd, Paget, DV 04, Bermuda
main 441-295-3923 fax 441-295-3983 northrockspine.com

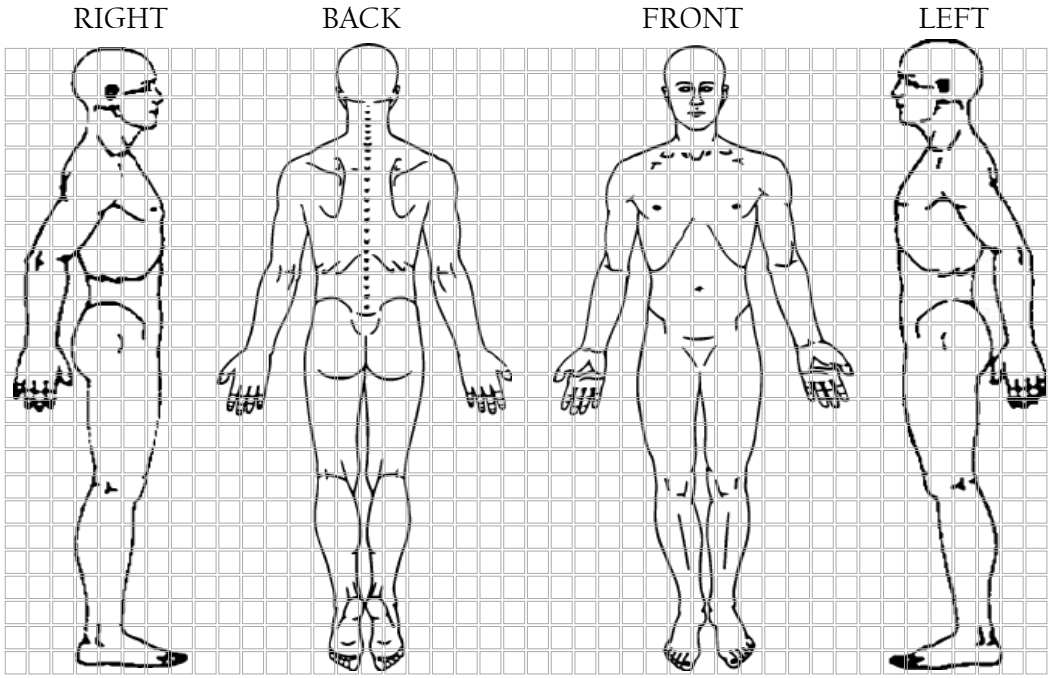
PAIN AND DISABILITY: (Section B)

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.

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



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**

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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 or ☐hours (check one)

☐ Stand longer than ____☐min or ☐hrs (check one) ☐Lift over _____lbs

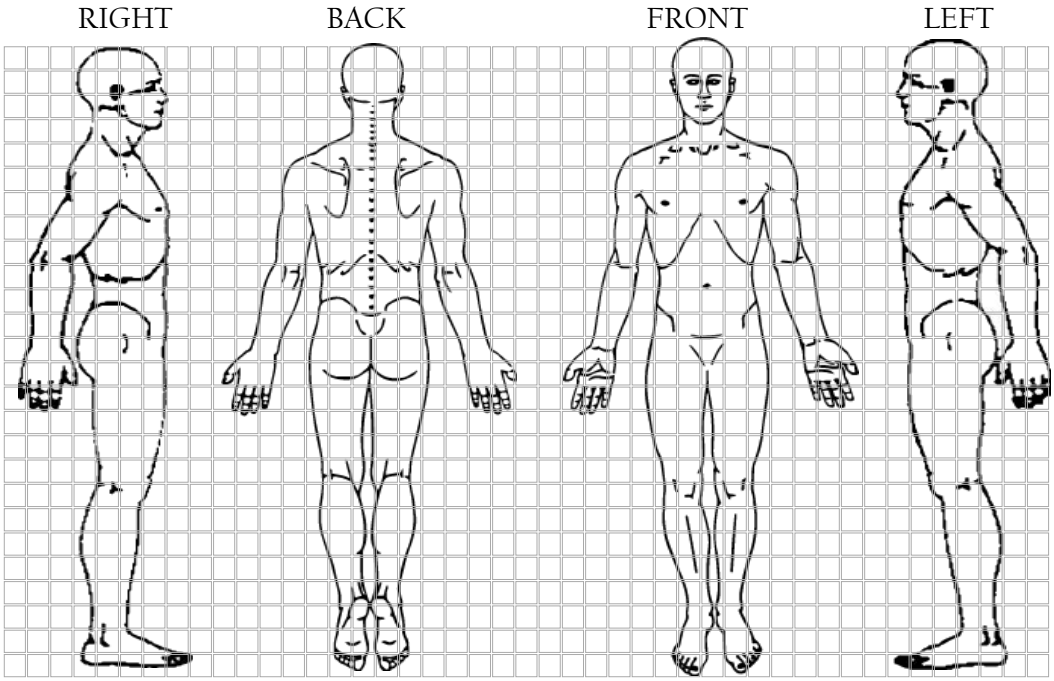
NUMBNESS/TINGLING (Section C)

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).



My numbness and tingling are made worse while.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ heat ☐ Ice ☐ exercising ☐ Frequently change of position

☐ sports (list)_____ ☐ **Nothing makes my numbness or tingling worse**

My numbness and tingling are made better while.....

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ lifting ☐ driving

☐ heat ☐ Ice ☐ exercising ☐ Frequently change of position

☐ sports (list)_____ ☐ **Nothing makes my numbness or tingling 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

☐ 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

☐ Frequent falling or stumbling

☐ Unable to stand up straight

☐ Leakage of Urine or staining underwear

☐ Impotence

☐ **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 Hospital)	☐	☐	☐	☐
	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 or currently take. Please include last date used, dose, number of pills per day and if the medication helped.
(**examples** = Naproxen, Voltaren, Ibuprofen, Feldine, Orudis, Indocin, Vicodin, Percocet, Oxycontin, Darvocet, Morphine, Soma, Flexeril, Robaxin, Skelaxin, Baclofen, Celebrex, Mobic, Neurontin, Lyrica, Elavil, Cymbalta, Ultram, Trazadone etc)

When last used? mm/yy	Medication (e.g. Motrin)	Dose (e.g. 800mg)	Number of pills per day (e.g. 4)	Did the medication help? (e.g. very helpful)

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

(Complete all areas below)

MEDICAL HISTORY

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

☐	Diabetes(Sugar)	☐	Seizures	☐	Hypertension (high blood pressure)
☐	Stroke	☐	**Heart Disease**	☐	Emphysema
☐	Brain Aneurysm			☐	COPD
☐	Hepatitis	☐	Anemia	☐	Asthma
☐	HIV/AIDS	☐	Blood Clotting Problems	☐	Osteoporosis/Osteopenia
☐	Valley Fever (coccidiomycosis)	☐	Kidney problems (i.e. renal failure, stones, infection)	☐	Cancer (type): _____ _____
☐	Tuberculosis	☐	Thyroid	☐	Stomach Ulcers
☐	Other Joint Pain	☐	Rheumatoid Arthritis	☐	Reflux Disease
☐	Depression	☐	Hiatal Hernia	☐	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	Office Phone Number	Issue or Problem

MEDICATION ALLERGIES

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

☐ I am allergic to (check all that apply):

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(Sugar)	☐	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			☐	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 (check one)?

☐Single	☐Married	☐Separated	☐Divorced	☐Widowed

What is your living situation (check one)?

☐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 (check one)

☐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 (Uncontrolled defecation)
☐	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.

The End