OrthopedicSpecialists

Spine Questionnaire
for Michael C. Chabot, D.O.

Name: _____ Age: _____ Date of Visit: _____

Primary Care Physician: _____

Referring Physician / Agency: _____

For Purpose of: _____

What are your current symptoms? _____

How long has the problem been present? _____ Years _____ Months

Are your symptoms associated with an injury? ☐ Yes ☐ No

Date of injury: _____ Where did injury occur? _____

To which area of body? ☐ Neck(base of skull to shoulders) ☐ Mid Back ☐ Low Back

Describe injury: _____

Prior Treatment:

Have you taken any medicine for your complaints? (please list) _____

Have you been medically treated for this present problem? ☐ Yes ☐ No

Treated by Dr(s): _____

Treatment prescribed: _____

Prior Diagnostic Studies Performed: (check all that apply)

☐ X-rays ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Nerve Studies ☐ Bone Scan

When? _____ Facility Name & Location? _____

Does Back/Neck Pain Radiate Into: LEGS? ☐ Yes ☐ No ARMS? ☐ Yes ☐ No

Pain Confined to: ☐ BACK ☐ NECK ☐ BOTH

LOW BACK/NECK PAIN ONLY

How severe was pain initially? ☐ Mild ☐ Moderate ☐ Severe

How severe is pain now? ☐ Mild ☐ Moderate ☐ Severe

Pain is: ☐Sharp ☐Dull ☐Aching ☐Generalized ☐Localized ☐Cramping ☐Burning ☐Electric/Shocking

PAIN RADIATING INTO LEGS OR ARMS

Pain is: ☐Sharp ☐Dull ☐Aching ☐Generalized ☐Localized ☐Cramping ☐Burning ☐Electric/Shocking

Do you have <u>numbness</u> in the leg(s) or arm(s)? ☐ Yes ☐ No Describe location:_____
(circle appropriate limb)

Do you have <u>weakness</u> in the leg(s) or arm(s)? ☐ Yes ☐ No Describe location:_____
(circle appropriate limb)

Symptoms are worsened by: ☐Standing ☐Walking ☐Sitting ☐Lying Down/Resting ☐Coughing/Sneezing ☐Bending Forward/Bending Backwards

Symptoms are improved by: ☐Standing ☐Walking ☐Sitting ☐Lying Down/Resting ☐Coughing/Sneezing ☐Bending Forward/Bending Backwards

There has been **no loss / some loss** of bowel or bladder control.
(circle one)

Has your ability to walk long distances been reduced? ☐ Yes ☐ No
How far can you walk before pain or symptoms stop you? Specify _____ blocks (one block = 100 feet)
Is there loss of erection? ☐ Yes ☐ No

Do you have a history of a previous back/neck injury? ☐ Yes ☐ No

Sought medical treatment on (date) _____ from Dr. _____

What was your diagnosis? _____

Was it work-related? ☐ Yes ☐ No

Comments: _____

_____

_____

Past Medical History: (please circle any conditions you have or have had in the past)

Asthma	Bleeding Problems	Gastritis
Shortness of Breath	Stroke	Peptic Ulcer Disease
Tuberculosis	Seizures	GI Bleeding
Emphysema	Paralysis	Head or Spinal Injury
Chronic Cough	Thyroid Problems	Multiple Sclerosis
High Blood Pressure	Kidney Disease	Neck Pain or Neck Injury
Low Blood Pressure	Liver Disease	Back Pain or Back Injury
Coronary Artery Disease	Hepatitis A, B, or C	Numbness in Hands or Feet
Angina	Arthritis (Hip, Knee, Shoulder)	Spinal Stenosis
Myocardial Infarction	Endometriosis	Herniated Disc in Neck or Back
Congestive Heart Failure	HIV	Cancer - what type? _____
Mitral Valve Prolapse	Depression	Diabetes - how many years? _____
Blood Clots	Anxiety	Peripheral Neuropathy
Anemia	Schizophrenia	Peripheral Vascular Disease

Have you or are you being treated for any other condition or disease not listed above? If yes, please list:

_____

Have you been treated for an emotional or psychiatric disorder? ☐ Yes ☐ No
Have you been hospitalized for a psychiatric condition? ☐ Yes ☐ No
Have you had ECT treatment? ☐ Yes ☐ No
Have you <u>been</u> drug/chemically dependent? ☐ Yes ☐ No
Are you <u>currently</u> drug/chemically dependent? ☐ Yes ☐ No

Surgeries (List All Surgeries)	**Dates**

Any Problems with Anesthesia? Yes / No

Medications (List All)	

Allergies (List All Medication Allergies & Your Reaction)

Pharmacy Information
Pharmacy Name: _____
Phone # _____
Fax # _____

Family History: *(Check those that apply)*

	Mom	**Dad**	**Sibling**
Heart Disease/MI	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Cancer type _____	☐	☐	☐
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Seizures	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Thyroid Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Mental Illness	☐	☐	☐
Acid Reflux/Ulcer	☐	☐	☐
Unknown	☐	☐	☐
None	☐	☐	☐

Social History:

Do you smoke? Yes / No
Packs per day? _____ for _____ years

Do you drink alcohol? Yes / No
Drinks per week? _____

Do you have a history of drug or alcohol abuse? Yes / No

Do you use a cane, walker, wheelchair? Yes / No
(circle one)

Are you married? Yes / No

Does someone live at home with you? Yes / No

Level of education _____

Are you presently pregnant? Yes / No
If yes, E.D.C _____

Additional comments: _____

_____

_____

Employment Information:

Employment Title: _____

Description of Duties: _____

You are currently working ▪ regular duty ▪ light duty ▪ off duty

If you are not working, what was your last date of employment? _____

Job duties require:

_____ Lifting: Weight range	____ lbs.	____ continuously	____ frequently	____ occasionally
_____ bending and squatting		____	____	____
_____ sitting		____	____	____

General:

Your general state of health is: ____ Excellent ____ Good
____ Fair (elaborate)_____
____ Poor (elaborate)_____

Height: _____ Weight: _____ lbs. _____ with no change
_____ recent significant weight GAIN of _____ lbs.
_____ recent significant weight LOSS of _____ lbs.

(PLEASE GO TO THE NEXT PAGE)

Pain Level Shortly After Injury

* Circle the number on the line below that represents your pain at its least.

* Circle the number on the line below that represents your pain at its worst.

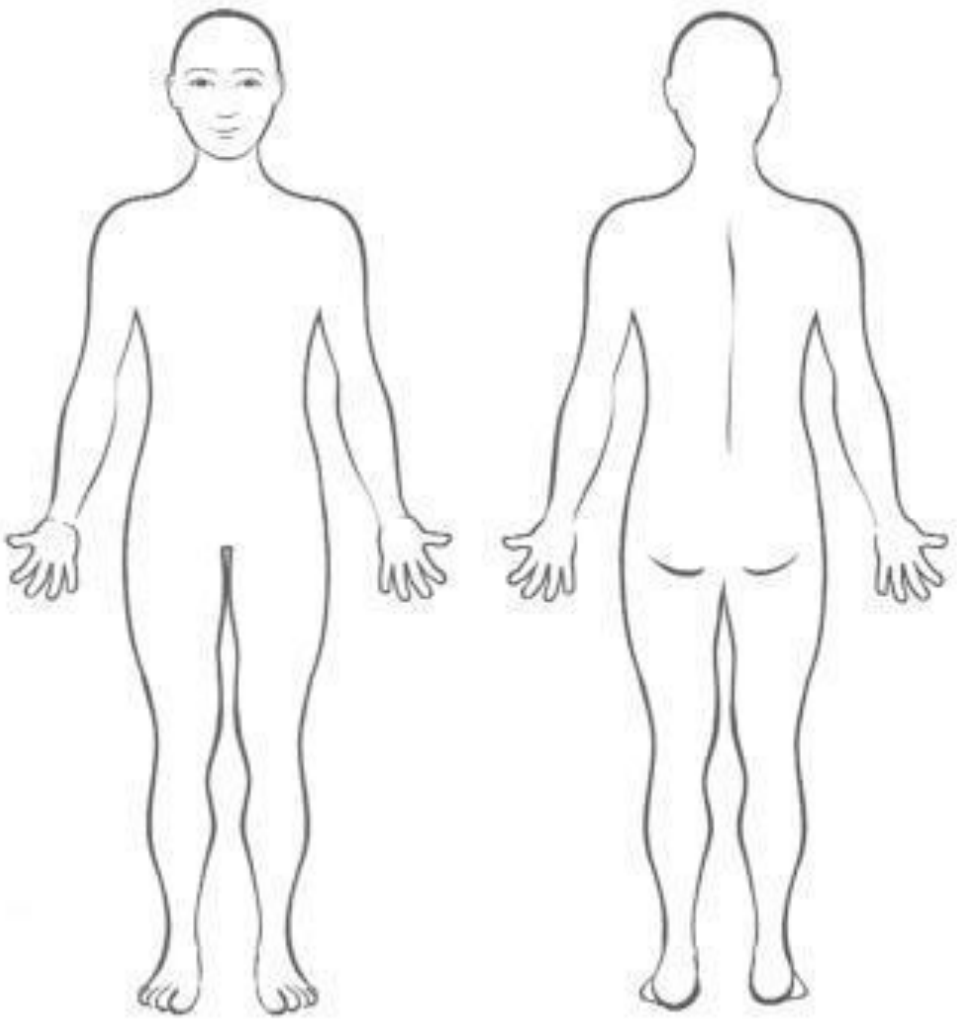
* Place an "X" on the line below that represented your pain **shortly after the injury**.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate** **Severe** **Excruciating**

Indicate on the diagram below where your pain was located and what type of pain you were experiencing **shortly after the injury** **(If there was no injury, skip to the next page).** Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching



Pain Level Today

* Circle the number on the line below that represents your pain at its least.

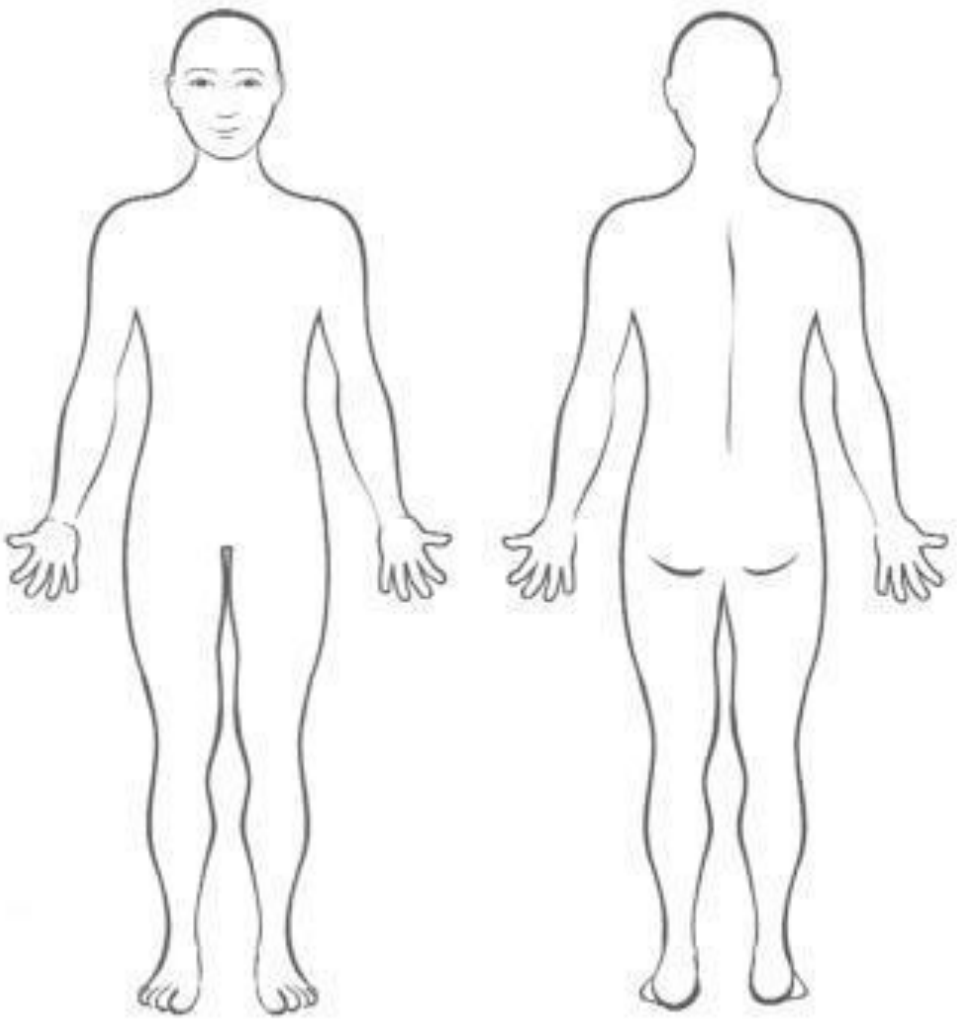
* Circle the number on the line below that represents your pain at its worst.

* Place an "X" on the line below that represents your pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching



----------For Office Use Only----------

Review of Systems:

General:

Gait:

Integument:

HEENT:

Neck:

Lungs:

Cardiovascular:

GI:

GU:

Psychological:

Joints:

Hematologic:

Musculoskeletal:

Neurologic:

----------For Office Use Only----------

Physical Examination:

General:

Gait:

Integument:

HEENT:

Neck:

Lungs:

Cardiovascular:

Abdomen:

Psychological:

Joints:

Musculoskeletal:

Neurologic:

Vascular:

PLAN

Diagnostics:	Meds:	Injections	Therapy	IN-OFFICE Injections
Lumbar MRI	Naproxen	Lumbar ESI- TF or IL	physical therapy	sacroiliac injections_____
Cervical MRI	Ibuprofen	Cervical ESI	work conditioning	trigger point injections x _____
Thoracic MRI	Soma	Lumbar SNRI	work hardening	muscle groups_____
Lumbar myelo/CT	Flexeril	Cervical SNRI	FCE	_____
Cervical myelo/CT	Medrol Dose Pak	Lumbar facet joint		hip bursa injection_____
LE EMG/NCV, bilat	Norco	Cervical facet joint		ulnar nerve injection_____
UE EMG/NCV, bilat	Percocet	SI joint inj under fluoro		IlioTibial Band injection_____
DEXA (bone density)	Neurontin	hip joint inj under fluoro		carpal tunnel injection_____
Arterial Doppler	Flector patches			
Bone scan	Ultram			
Lumbar disco/CT	Mobic			
Cervical disco/CT	Tizanidine			
Lumbar CT w/ recons				
Cervical CT w/ recons				
Lumbar MRI w & w/o Gadolinium				
Cervical MRI w & w/o Gadolinium				

OTHER RECOMMENDATIONS:_____ F/U_____