SPINE QUESTIONNAIRE

Kevin D. Rutz,MD   Kyle A.Conrod,PA-C   Loren S. Vandergriff ,ANP

Thank you for taking the time to fill out this form. Please fill in all the sections to the best of your ability before your appointment. The information you provide greatly enhances our ability to give you the best care possible.

Name: ______________________________ Age: ______ Today's Date: __________
Referring Physician / Agency____
Address of referring physician / Agency ____

____

We will prepare a typed report of your visit and examination. A copy of the report is automatically sent to your referring physician. If this is a Worker's Compensation claim a copy of the report will automatically be sent to your employer / insurance carrier by law.

Please provide the name and address of any other health care provider to whom you would like us to send a copy of your report.

____
____
____

Description of Current pain

When did, the problem begin? ___years /___months ago (Date: __________________)

The problem began _____suddenly _____gradually
_____at work _____at home
_____in an accident _____for no apparent reason

If the problem was an accident, please give the exact date of the accident and explain what happened.

____
____
____

Where is your problem? __Neck __Upper Back __Lower Back
__Right Arm __Right Leg
__Left Arm __Left Leg

What percent of your pain is in your: Back___% Leg(s)___% Neck___% Arm(s)___%

Back or neck pain only:

How severe was the pain initially? ___Mild ___Moderate ___Severe
How severe is the pain now? ___Mild ___Moderate ___Severe
Describe the pain: ___Sharp ___Dull ___Aching ___Burning
___Cramping ___Localized ___Generalized

Does your back or neck pain radiate into your: Leg(s) __yes __no Arm(s) __yes __no

Pain radiating into leg(s) (or arm(s) only:

How severe was the pain initially? ___Mild ___Moderate ___Severe
How severe is the pain now? ___Mild ___Moderate ___Severe
Describe the pain: ___Sharp ___Dull ___Aching ___Burning
___Cramping ___Localized ___Generalized

Do you have numbness/pain in the leg(s) or arm(s)? ___yes ___no
Describe location: ____

Do you have weakness in the leg(s) or arm(s)? ___yes ___no

Describe location: ____

The problem is worse:

_____bending _____twisting _____lifting
_____sitting _____standing _____walking
_____cough _____sneeze _____straining
_____in the morning _____after an active day _____all the time
_____with exercise _____Physical Therapy
_____other (____)

The problem is better:

_____with rest _____when I lie down _____when I sit down
_____in the morning _____after I get up and moving for a while
_____with standing _____with walking _____with heat/cold
_____with medication _____with a brace _____with injections
_____with Physical Therapy _____with exercise _____with TENS unit
_____other (____)

How long are you able to sit comfortably? ___less than an hour ___more than an hour

Has your ability to walk long distances been reduced ___ yes ___no

How far can you walk before your symptoms stop you?

Specify ___blocks (One block = 100 feet)

Does your pain often wake you from sleep? ___yes ___no
Has there been a loss of bowel or bladder control? ___some loss ___no loss
Is there loss of erection since the problem started? ___yes ___no

Overall the problem is:

_____getting better
_____getting worse
_____comes and goes (good days and bad days)
_____improved for a while but stopped improving at an unacceptable level (how long have your symptoms not improved? ___________________)

_____other (____)

Is there a lawsuit currently under way with regard to this problem? ___ With whom? ___
Is this problem a workman's compensation case? _______________________________
Have you seen another spine surgeon and have made this appointment solely for a second opinion? _______

Past Spine Problems

Have you had neck or back problems in the past? If so, please explain what your past problem was and what treatment you had. If you had spine surgery, please explain what you had done, who did it, and when it was done.________________________________
____
____
Was your past problem work related? ___yes ___no

Which of the following test have you had for your current problem?

Test	Date	Where the test was done
X-rays	____________________	__________________________________
MRI	____________________	__________________________________
CT Scan	____________________	__________________________________
Myelogram	____________________	__________________________________
Bone Scan	____________________	__________________________________
Discograms	____________________	__________________________________
EMG (nerve test)	____________________	__________________________________

Which of the following treatments have you had for the current problem?

Treatment	Date	Doctor's Name	Result of Treatment
Physical Therapy	___________	_____________	___________________________

What was done? ____

Did your therapy include a specific back or neck strengthening exercise program which you did at home in addition to what you did in the therapy clinic? _______

If yes, how long did you do the exercises? ________________________________

__Chiropractic	___________	_____________	___________________________
__Brace	___________	_____________	___________________________
__Epidural Steroid Injection (cortisone shot in the back)	1st ________	_____________	___________________________
	2nd ________	_____________	___________________________
	3rd ________	_____________	___________________________
__TENS unit	___________	_____________	___________________________
__Traction	___________	_____________	___________________________
__Other	___________	_____________	___________________________

What medications have you had for your current problem? Please include all prescription and over the counter medicines such as anti-inflammatory pills (like Motrin, ibuprofen, Aleve, Naprosyn, Celebrex, Mobic etc.), oral steroids, pain pills (like Vicodin, Lortab, Darvocet, Oxycontin) and pills for nerve pain (like Neurontin, Pamelor, Elavil, Lyrica etc.).

Medicine	Dose	Frequency	Doctor's Name	Result of Medicine
________	_____	________	____________	_________________________
________	_____	________	____________	_________________________
________	_____	________	____________	_________________________
________	_____	________	____________	_________________________
________	_____	________	____________	_________________________

Past Medical History

1.) Have you ever been treated for any of the following illnesses (if yes, please circle)?

High blood pressure	Heart Disease/Heart Attack	Diabetes
Asthma	Emphysema/Bronchitis	Cancer
Ulcers	Kidney disease	Hepatitis
Epilepsy	Stroke	Blood clots
Depression	Auto-immune disease	Anxiety
Fibromyalgia	Irritable bowel syndrome	Migraines

Please comment on any illness checked above or write in other conditions

____

____

2.) List the surgeries you have had and what they were for:

____
____
____

3.) List current medications, dosages, and condition prescribed for:

Medication	Dose	Frequency	Condition Prescribed for
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________
____________	________	____________	________________

List any over-the-counter medications, such as diet, allergy, or herbal pills, that you take:

____
____

4.) **Allergies:** Please list which medications you are allergic to and what reaction you had to them:

____
____

Social History

Marital status:	__Married	__Single	__Divorced
Children:	__No	__Yes – Number and age(s) ____________	
I live:	__Alone	__With someone	
Alcohol use:	__No	__Yes – Number of drinks per week ________	
Tobacco use:	__No	__Yes – Packs per day/ years smoked ________	

Have you ever had a problem with drug or chemical addiction? Yes/No Please explain

____

Do you use a cane, walker, or wheel chair? ______________________________

Are you pregnant? __No __Yes – Due date ______________________

Family History

Are there any diseases that run in your family (e.g. diabetes, rheumatoid arthritis, cancer, scoliosis, bleeding disorders, or anesthetic complications such as malignant hyperthermia)?

____
____

Mother	__Alive	__Deceased – Cause of death ______________
Father	__Alive	__Deceased – Cause of death ______________

Review of Systems – (Circle all that apply to you within the last two years and explain as needed)

Constitutional Symptoms (fever, chills, fatigue, weight loss or gain over 20 pounds)
Explain ____

Eyes (double vision, blurring, glasses)
Explain ____

Ears, Nose, Throat and Mouth (hearing loss, sinusitis, hoarseness, vertigo)
Explain ____

Cardiovascular (chest pain, palpitations)
Explain ____

Respiratory (shortness of breath, asthma, chronic cough)
Explain ____

Stomach/Intestinal(appetite loss/nausea, diarrhea/constipation, heart burn,abdominal pain
Explain ____

Urology (hesitancy, incontinence, burning urination, menstrual problems)
Explain ____

Skin/Breast (rashes, lesions, scars)
Explain ____

Neurological (speech, swallowing problems, stroke, seizures, headaches)
Explain ____

Psychological (depression, hallucinations, sleep disturbances, alcoholism, drug addiction)
Explain ____

Endocrine (growth/hair changes, excess thirst, decreased energy)
Explain ____

Hematologic/Lymphatic (easy bruising, blood clots, bleeding disorders, anemia, swelling)
Explain ____

Allergic/Immunologic (food allergies, immune deficiency, frequent infections)
Explain ____

Employment History

Employment Title____

Description of Duties:____

Employer: ____

I am working ___regular duty ___light duty __off duty

I have been given___no working restrictions
____ the following working restrictions ______________________

The last day I worked was ______________________ __I am still working

If not currently working it is because:___Retired ___Medical Leave ___Laid Off
___Disabled ___ on SSD ___Fired

My job requires:

____Lifting: Weight range __lbs.___continuously ___frequently ___occasionally
____Bending and squatting ___continuously ___frequently ___occasionally
____Sitting ___continuously ___frequently ___occasionally
____Standing ___continuously ___frequently ___occasionally
____Computer work ___continuously ___frequently ___occasionally

A Few More Important Questions:

1.)Aside from your current problem, how would you describe your general state of health? ___good ___fair ___poor

2.) Do you feel your problem is changing who you are as a person?

____

3.) Do you feel that you are under a lot of stress?

____

4.) Do you already have a diagnosis for your current problem? If so, what is it?

____

5.) What does your problem prevent you from doing (work, hobbies, sports, having a good quality of life, etc.)?

____

6.) Do you feel that your problem is severe enough to consider surgery as an option?

____

7.) Do you think that you need surgery?

____

8.) If your doctor could only fix one thing (back or neck or leg or arm pain), what would you choose?

____

9.) What is your main goal for your office visit?

____

10.) Is there anything you think your doctor needs to know that you have not answered in this questionnaire already?

____

11.) Do you have any specific questions about your problem you would like your doctor to answer? Please list them. ____

____

I have completed all the questions in this form truthfully, completely, and to the best of my knowledge.

______________________________ ______________________________

Patient or Guardian's signature Date

Below is for office use only

I certify that the above medical history, past surgical history, medications, allergies, social history, family history and review of systems has been reviewed.

______________________________ ______________________________

Physician or P.A. Signature *Date*

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