

VERMONT ORTHOPAEDIC CLINIC

SPINE QUESTIONNAIRE

Please answer all questions.

Date of visit: _____

Name: _____

Date of birth: _____

Age: _____ What hand do you write with? _____

Referring Doctor: _____

Primary Doctor: _____

Is this a work related injury Yes _____ No _____

If yes, what is the date of the injury? _____

Where is your pain? _____

When did your pain begin? _____

What do you think caused the pain? _____

Describe how and when these problems started: _____

Since it started, is the pain: Increasing _____ Decreasing _____ Same _____

Have you had any other spinal pain before this episode? Yes _____ No _____

Describe: _____

Have you ever had surgery on your neck or back before? Yes _____ No _____

Please list below:

Date	Surgeon	What Operation	Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please fill out the appropriate sections: NECK PAIN or BACK PAIN.

If you have both, please fill out both.

NECK PAIN

Does the neck pain: Come and go _____ or Always present _____

Is the pain in your neck: Sharp like a knife _____ Aching pain _____ Other _____

Describe: _____

What makes the pain worse? _____

What makes the pain better? _____

Do you have pain in the arms? Yes _____ No _____

Which arm? Right _____ Left _____ Both _____

Does the arm pain: Come and go _____ or Always present _____

Does the pain go below the elbow? Yes _____ No _____

Which part of the arm is painful? Inside _____ Outside _____ Back _____ Front _____

Which part of the forearm is painful? Inside _____ Outside _____ Back _____ Front _____

Which part of the hand is painful? Top _____ Bottom _____ Inside _____ Outside _____

Do your arms get numb? Yes _____ No _____

Which areas: _____

Do your arms get weak? Yes _____ No _____

Which areas: _____

What bothers you more? Neck _____ Arms _____ Equal _____

On a scale of 0 to 10, with 0 being no pain and 10 being the most painful, how bad is

your **NECK PAIN**: on the average _____ at its worst _____

your **ARM PAIN**: on the average _____ at its worst _____

Please fill out the appropriate sections: NECK PAIN or BACK PAIN.

If you have both, please fill out both.

BACK PAIN

Does the back pain: Come and go _____ or Always present _____

Is the pain in your back: Sharp like a knife _____ Aching pain _____ Other _____

Describe: _____

What makes the pain worse? _____

What makes the pain better? _____

Do you have pain in your legs? Yes _____ No _____

Which leg? Right _____ Left _____ Both _____

Does the pain go below the knees? Yes _____ No _____

Which part of the thigh is painful? Inside _____ Outside _____ Back _____ Front _____

Which part of the calf is painful? Inside _____ Outside _____ Back _____ Front _____

Which part of the foot is painful? Top _____ Bottom _____ Inside _____ Outside _____

Do your legs get numb? Yes _____ No _____

Do your legs get weak? Yes _____ No _____

What bothers you more? Back _____ Legs _____ Equal _____

On a scale of 0 to 10, with 0 being no pain and 10 being the most painful, how bad is

your **BACK PAIN**: on the average _____ at its worst _____

your **LEG PAIN**: on the average _____ at its worst _____

GENERAL

What activities have you stopped because of this pain? _____

Do you have full control of your bowels and bladder? Yes _____ No _____

If no, please describe: _____

Has the pain affected your sex life? Yes _____ No _____

Do you often lose your balance and feel clumsy? Yes _____ No _____

If yes, please describe: _____

What is the farthest distance you can walk? _____

What stops you? _____

Is the pain bad enough that you would consider surgery for some relief? Yes _____ No _____

What other doctors, clinics, emergency rooms, or hospitals have you seen for your current spinal problem?

Name	Address	Date of First Visit	Date of Last Visit
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Have you had Physical Therapy for you back/neck pain? Yes _____ No _____

When was the last time you went? _____

How long did you go to therapy? _____

What types of therapy did they do? _____

Did therapy help? A lot _____ A little _____ Temporary _____ None _____

Have you had Chiropractic Care for your back/neck pain? Yes _____ No _____

When was the last time you went? _____

How long did you go to chiropractor care? _____

Did chiropractic care help? A lot _____ A little _____ Temporary _____ None _____

Have you seen a pain management specialist for your back/neck pain? Yes _____ No _____

Have you had epidural spinal injections for you back/ neck pain? Yes _____ No _____

Did they help? Yes _____ No _____

How many have you had? _____ How long did they last for? _____

When was the last one? _____

What pain medications are you taking for your back and/or neck pain?

Drug	Dose	Last time taken	Prescribing Doctor

Have you had X-rays for you back/neck pain? Yes _____ No _____

When was it done? _____ Where was it done? _____

Have you had a MRI (Magnetic resonance image) for your back/neck pain? Yes _____ No _____

When was it done? _____ Where was it done? _____

What other tests have you had done for your back/neck pain?

Test	Date	Where

WORK/SOCIAL HISTORY

When did you last work or do normal activities? _____

Have you returned to work? Yes _____ No _____ If yes, date _____

Have you been released back to work? Yes _____ No _____ If yes, date _____

What restrictions are you currently on? _____

How long have you had your most recent job? _____

List your hobbies and recreational activities: _____

Do you smoke? Yes _____ No _____ If yes, how much? _____

Did you ever smoke? Yes _____ No _____ If yes, when did you quit? _____

Do you drink any alcohol? Yes _____ No _____ If yes, how much? _____

Do you currently use recreational drugs? Yes _____ No _____

Have you used recreational drugs in the past? Yes _____ No _____

If yes, what drugs? _____

PERSONAL AND FAMILY MEDICAL HISTORY

Please indicate specific disease and which family member if applicable

	Self	Family	Comments
Lung Disease	_____	_____	_____
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Liver Disease	_____	_____	_____
Arthritis	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Cancer	_____	_____	_____
Bleeding problems	_____	_____	_____
Concussion	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Has there been any change in your health status since you were last seen in our office? _____

List ALL prior Surgeries (and dates):

Are you experiencing any of the following:

Constitutional: none Fatigue Fever Unintentional weight loss (___ lbs in ___ months)
Weight gain (___ lbs in ___ months)

Neurological: none Headaches Generalized Weakness Numbness or tingling Dizziness
Recent head trauma

Eyes: none Vision changes

ENT: none Congestion Runny nose Hoarseness

Cardiovascular: none Leg swelling Color or temperature changes to fingers or toes

Respiratory: none Cough

GI: none Diarrhea Constipation Abdominal pain Nausea Vomiting

GU: none Incontinence Difficulty with urination Abnormal or absent periods

Musc: none Muscle pains Joint pain Muscle weakness Joint Swelling Chest wall pain

Skin: none Rash Color or temperature changes Bruising

Psych: none Depression Mood swings Sleep difficulty

Endo: none Excessive thirst Increased urination Hair loss New or unusual hair growth

Hem/Lymph: none Swollen lymph nodes Easy bruising Tendency to bleed

Allerg/Immuno: none Frequent infections

Are any of the above managed by another physician? Yes No

If yes, please CIRCLE the category above.

How long did it take you to get an appointment: ____ days ____ weeks

Did you have any problems scheduling your visit with us? Yes _____ No _____

Please explain: _____

Patient Signature: _____ Date: _____

MD/PA Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____