

# VERMONT ORTHOPAEDIC CLINIC SPINE QUESTIONNAIRE

Please answer all questions.

Date of visit: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_ What hand do you write with? \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

Is this a work related injury? Yes \_\_\_\_\_ No \_\_\_\_\_

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 \_\_\_\_\_

### **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: \_\_\_\_\_

\_\_\_\_\_

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 medications have you taken for your back/neck pain?

Drug	Dose	How many a day?	Last time taken
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal/Family Medical History-please indicate specific disease and which family member if applicable

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

List any previous surgery (and dates):

\_\_\_\_\_

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? \_\_\_\_\_