Spine & Sciatica Questionnaire

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(Please answer all questions completely)

Name:_____ **Date:**_____

Birthdate:_____**Height:**_____

Weight:_____

A. 1. **Referring doctor (name, facility or self):**_____

Primary care doctor (name, facility):_____

2. **Chief complaint (check those that apply):**

☐ ***Neck pain*** **Arm:** ☐ **pain** ☐ **weakness** ☐ **numbness**

☐ ***Back pain*** **Leg:** ☐ **pain** ☐ **weakness** ☐ **numbness**

3. **Age:**_____ **Sex:** ☐ **male** ☐ **female**

4. **How long has the pain (or your problem) been present?**_____

5. **What started the pain/ problem?**

_____

_____

B. **For patients for <u>neck or arm</u> pain only: (for back pain go to "C")**

1. What percent of your pain is neck and what % is arm pain?

☐ I have all neck pain

☐ I have all arm pain

☐ I have _____% arm pain

☐ I have _____% neck pain these should =100%

☐ For arm pain: _____% LEFT _____% RIGHT

2. Raising the arm: ☐ improves the pain ☐ worsens the pain ☐ no change

3. Moving the neck: ☐ improves the pain ☐ worsens the pain ☐ no change

4. There is: ☐ Weakness ☐ NO weakness in the arms or hands

5. There is: ☐ Numbness in the hands or arms ☐ NO numbness

6. Do you have difficulty picking up small objects like coins or buttoning your buttons? ☐ yes ☐ no

7. Do you have problems with balance, or trip frequently: ☐ yes ☐ no

END OF NECK QUESTIONS, please go to "D"

C. For patients with <u>back pain</u>, leg pain or weakness or weakness.

1. What percent of your pain is back pain (from mid-back to buttocks)?____%
2. What percent of your pain goes down each leg?
   ☐ LEFT _____% ☐ RIGHT _____%
3. Do you have pain that "shoots" or goes below your knees? ☐ YES ☐ NO
4. There is weakness of my:
   LEFT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no weakness
   RIGHT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no weakness
5. There is numbness of my:
   LEFT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no numbness

RIGHT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no numbness

6. The worst position for my pain is: ☐sitting ☐ standing ☐ walking

7. How many minutes can you stand in one place without pain?
☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

8. How many blocks can you walk without pain?
☐ 0-3 ☐ 4-7 ☐ 1 mile ☐ 2 miles or more

9. Lying down: ☐ eases my pain ☐make it worse ☐ no effect

10. Bending forward: ☐ eases my pain ☐make it worse ☐ no effect

D. ALL PATIENTS should answer the following:

1. Coughing or sneezing: ☐ eases my pain ☐make it worse ☐ no effect

2. There is: ☐ No loss of bowel or bladder control
☐ Loss of control since_____, describe _____.

3. I have: ☐ not missed any work because of this problem
☐ have missed (how much?) _____

4. TREATMENTS SO FAR INCLUDE:
☐ Physical therapy (How many visits? _____)
☐ Exercise program (How long? _____)
☐ Massage or Ultrasound
☐ Chiropractic ☐ Homeopathic or Acupuncture
☐ Braces
☐ Anti-inflammatory medications (e.g. Motrin or Naproxen)
☐ Narcotic medications (e.g. Tylenol #3, Vicodin, Darvocet)
☐ Steroid injections _____times.

How long did they relieve the pain for? _____

Are there any other non surgical treatments left that you have tried?(please list)

_____
_____

5. Previous doctors seen for this problem:
Doctor Specialty City Treatments

_____

_____

_____

_____

6. Diagnostic Tests done to evaluate this problem:

City Date

X-rays:

_____

Cat Scan:

_____

Myelogram

_____

MRI:

_____

EMG's:

_____

Bone Scan:_____

E. Your Medical History: (check all that apply) ☐ None apply

Heart Attack ☐	**Mental Illness** ☐	**Stomach Ulcers** ☐
Heart Failure ☐	**Kidney Stones** ☐	**Liver Trouble** ☐
High Blood Pressure ☐	**Kidney Failure** ☐	**Hepatitis** ☐
Osteoarthritis ☐	**Cancer** ☐	**Thyroid Trouble** ☐
Rheumatoid Arthritis ☐	**Alcoholism** ☐	**Bleeding Disorders** ☐
Ankylosing Spondylitis ☐	**Lung Disease** ☐	**Anemia** ☐
Gout ☐	**AIDS** ☐	**Serious Injuries (explain)** ☐
Osteoporosis ☐	**Tuberculosis** ☐	**Other:**_____
Diabetes ☐	**Asthma** ☐	_____
Stroke ☐	**Blood Clot in Leg** ☐	_____
Seizures ☐	**Blood Clot in Lung** ☐	

F. Surgical History (including spine):

OPERATION SURGEON & CITY DATE

_____

_____

_____

_____

_____
_____
_____
_____

G. Medications you take (list dose and frequency): ☐ None

_____
_____
_____
_____
_____
_____

H. Medications that you have tried for your problem:

_____
__
_____
__

I. Medication allergies: ☐ None

MEDICATION REACTION

_____ ☐ rash ☐ upset stomach ☐wheezing or shock ☐ other _____

_____ ☐ rash ☐ upset stomach ☐wheezing or shock ☐ other _____

_____ ☐ rash ☐ upset stomach ☐wheezing or shock ☐ other _____

J. Social history and habits:

1. **Work status: ☐ Homemaker ☐ Working ☐ Retired ☐ Disabled ☐ On leave**
2. **Occupation (current or most recent):**
   _____
3. **Date last worked** _____
4. **Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ cohabiting**
5. **I live: ☐ alone ☐ with:** _____
6. **Tobacco use: ☐ never ☐ cigar ☐ chew ☐ pipe**
   ☐ cigarettes _____packs/day for _____years (total)
   ☐ quit (when) _____
7. **Alcohol:**
   ☐ never or rare ☐ social ☐ drink frequently (more than twice week)
   ☐ alcoholic ☐ recovering alcoholic
8. **Drug use: ☐ never ☐ in the past ☐ currently ☐ IV drugs**
9. **Because of this problem do you have, or plan to have:**

☐ lawsuit ☐ workman's compensation claim ☐ unsure ☐ none

K. Family Medical History: (check all that apply): ☐ none apply

Stroke ☐ Gout ☐
Cancer ☐
Heart Trouble ☐ Seizures
☐ Bleeding Disorders ☐
High Blood Pressure ☐ Spine problems ☐
Alcoholism ☐
Diabetes ☐ Mental Illness ☐
Arthritis ☐ Kidney Trouble or Stones ☐

Other: _____

L. Review of Systems: (check all that apply): ☐ none apply

Reading Glasses ☐	Toothache ☐	Frequent Headaches ☐
Change of Vision ☐	Gum Trouble ☐	Blackouts ☐
Loss of Hearing ☐	Nausea or Vomiting ☐	Seizures ☐
Ear pain ☐	Stomach Pain ☐	Frequent Rash ☐
Hoarseness ☐	Ulcers ☐	Hot or Cold Spells ☐
Nosebleeds ☐	Frequent Belching ☐	Recent Weight Change ☐
Difficult Swallowing ☐	Frequent Diarrhea ☐	Nervous Exhaustion ☐
Morning Cough ☐	Frequent Constipation ☐	*Women Only:*
Shortness of Breath ☐	Hemorrhoids ☐	Irregular Periods ☐
Fever or Chills ☐	Frequent Urination ☐	Vaginal Discharge ☐
Heart or Chest Pain ☐	Burning on Urination ☐	Frequent Spotting ☐
Abnormal Heartbeat ☐	Difficulty Starting Urination ☐	Other: _____
Swollen Ankles ☐		
Calf Cramps w/Walking ☐	Get up more than once every night to urinate ☐	_____
Poor Appetite ☐		

Is your primary care doctor aware of the above checked problems?
☐ *yes* ☐ *no*

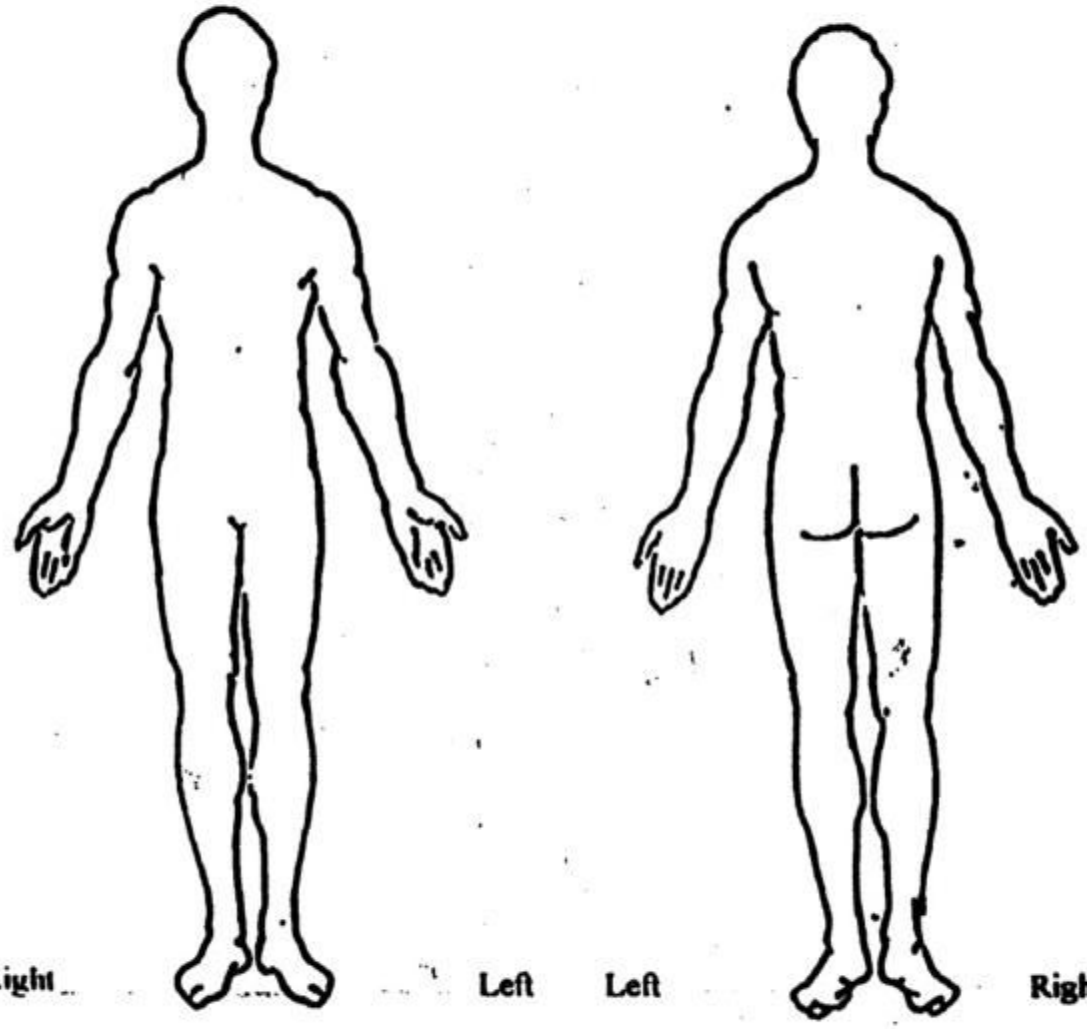
Surgery does have significant risks such as: 1% risk of major complications (death or paralysis) as well as approximately a 15% risk of lesser complications (wound infection, spinal fluid leak, blood clots, hardware/implant complications). Other risks may apply to your specific problem.

Do you feel that your problem limits your activities enough or causes you enough pain after having surgery? ☐ Yes ☐ no

Patient Pain Drawing

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using The appropriate symbol. Mark the areas of radiation. Include all affected areas. To Complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
Λ Λ Λ	= = =	0 0 0	x x x	/ / /



How bad is your pain now?
Please mark with an X on the body where the pain is worst now.
Please mark on the line how bad your pain is now.

No pain _____ Worst possible pain

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