SOUTHERN CALIFORNIA SPINE INSTITUTE

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NEW PATIENT QUESTIONNAIRE

Name:_____ Date: _____

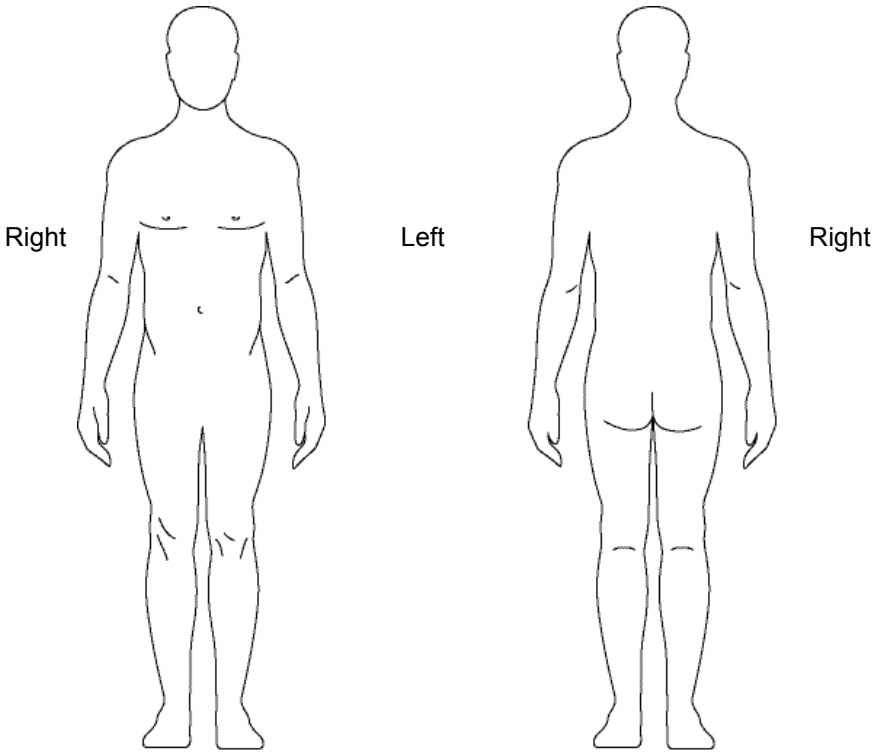
Age: _____ Weight: _____ Height: _____ ❑ Right-handed ❑ Left-handed

Pain Drawing

INSTRUCTIONS:
Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

KEY:

///// Stabbing	XXXX Burning	0000 Pins and Needles	==== Numbness	++++ Aching



Neck Pain_____ %
Arm Pain _____ %
Back Pain_____ %
Leg Pain _____ %
Total _____ %

Pain Level: 0 1 2 3 4 5 6 7 8 9 10
(Circle your current pain level)

0	No pain
1	Mild pain; you are aware of it, but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide

Please feel free to ask any questions you would like answered during today's visit:

1._____

2._____

3._____

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1. List all the physicians, physical therapists and chiropractors you have consulted for your present condition: _____

   _____

2. Have you had any of the following studies? (Please check)
   - ❑ Regular X-rays
   - ❑ CT scan (short tube)
   - ❑ MRI (long tube)
   - ❑ EMG (nerve/muscle test)
   - ❑ CT Myelogram
   - ❑ Discogram
   - ❑ Bone scan
   - ❑ Other: _____

3. Date of injury or symptom onset: _____/_____/_____

4. Type of injury:
   - ❑ Work-related injury
   - ❑ Injury related to a motor vehicle accident
   - ❑ Sports-related injury
   - ❑ Unrelated to any particular incident
   - ❑ Other: _____

5. Briefly describe how the injury or symptoms occurred: _____

   _____

   _____

   _____

6. If you were involved in a motor vehicle accident, please check all that apply to you:

   ❑ Driver ❑ Passenger ❑ Hit head ❑ Lost consciousness (___ minutes)

   ❑ Wearing seatbelt ❑ Car equipped with airbags ❑ Airbag deployed

   ❑ Evaluated by ambulance/EMT ❑ Taken to ER/hospital (Name_____)

   ❑ Right foot on brake at time of impact ❑ Rear-ended ❑ Broad-sided

7. If you have suffered any **other injuries** at the time you injured your neck, back or joints, please describe: _____

8. If you have suffered **previous neck, back or joint problems** *prior* to this episode, please describe:

   _____

   _____

9. Recently, are your symptoms: ❑ Worse ❑ Better ❑ Same

10. Are your symptoms: ❑ Constant ❑ Intermittent (Occasional)

11. Is your pain: ❑ Mild ❑ Moderate ❑ Severe

12. Have you experienced numbness or tingling in your limbs? (Describe) ❑ YES ❑ NO

_____

13. Check which of the following activities change the nature of your pain, *if applicable*:

	Aggravates Pain	*Relieves Pain*
Sitting	❑	❑
Standing	❑	❑
Walking	❑	❑
Rest	❑	❑
Rising from a seated position	❑	❑
Bending forward	❑	❑
Rising from a bent forward position	❑	❑
Bending backward	❑	❑
Lying on your back	❑	❑
Lying on your stomach	❑	❑
Going up stairs	❑	❑
Going down stairs	❑	❑
Driving	❑	❑
Coughing	❑	❑
Sneezing	❑	❑
Looking up	❑	❑
Looking down	❑	❑
Turning head to right	❑	❑
Turning head to left	❑	❑
Overhead activities	❑	❑
Using computer	❑	❑
Ice/cold packs	❑	❑
Heat	❑	❑
Other:_____	❑	❑
(Women) Menstrual cycle	❑	❑

14. Which current medications are you taking for pain? (Please list) ❑ NONE

_____

_____

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15. Previous pain medications (if applicable): ❑ NONE

Anti-Inflammatory Medication:	❑ Medrol Dose Pack	❑ Prednisone	❑ Aspirin	❑ Iboprofen / Motrin / Advil	
	❑ Indocin / Indomethacin	❑ Mobic / Meloxicam		❑ Daypro	
	❑ Voltaren	❑ Lodine	❑ Arthrotec	❑ Feldene	❑ Clinoril
	❑ Orudis	❑ Ansaid	❑ Toradol	❑ Celebrex	❑ Vioxx
	❑ Bextra	❑ Naproxen / Naprosyn / Aleve / Anaprox			❑ Relafen / Nabumetone
Analgesic:	❑ Tylenol / Acetominophen	❑ Ultram	❑ Lidoderm Patch		
Narcotic:	❑ Darvocet	❑ Vicodin	❑ Lortab	❑ Lorcet	❑ Norco
	❑ Tylenol#3	❑ Percocet	❑ Percodan	❑ Oxycontin	❑ Morphine Sulfate
	❑ Duragesic / Fentanyl	❑ Hydrocodone			
Regulated Narcotic:	❑ Dilaudid	❑ Methadone			
Muscle Relaxers:	❑ Skelaxin	❑ Robaxin	❑ Zanaflex	❑ Flexeril / Cyclobenzaprine	
	❑ Soma / Carisprodol				
Antidepressant:	❑ Trazadone	❑ Doxepin	❑ Effexor	❑ Wellbutrin	
	❑ Celexa	❑ Prozac	❑ Paxil	❑ Zoloft	
	❑ Remeron	❑ Pamelor / Nortriptyline		❑ Elavil / Amitriptyline	
Other:	❑ Neurontin	❑ Trileptal	❑ Topamax	❑ Other _____	

16. Are you currently taking medications for other medical conditions? (Please list) ❑ NONE

_____

_____

17. Are you allergic to any medications? ❑ YES ❑ NO (If "Yes," please list)

_____

_____

18. Are you allergic to X-ray dye? ❑ YES ❑ NO ❑ UNKNOWN

19. Have you ever had treatment with: (Please list name or location and area treated)

❑ Physical Therapist (PT) _____

❑ Chiropractor (DC) _____

❑ Osteopathic Physician (DO) _____

❑ Accupuncture _____

❑ Prolotherapy _____

❑ Biofeedback _____

❑ Pain Psychologist _____

20. Have you ever had injections for your pain? ❑ YES ❑ NO ❑ Type: ❑ Trigger Point_____
❑ Epidural _____
❑ Other _____

21. Have you ever had spine surgery in the past (please include dates)? ❑ YES ❑ NO
(If No, go to question #31)

_____

_____

22. Did you improve after your most recent surgery? ❑ YES ❑ NO

23. What symptoms improved? _____ How long? _____

24. What was your work status after the last surgery?
❑ Returned to the same job ❑ Changed jobs and returned to work
❑ Returned to work part-time ❑ Never returned to work

25. List all previous surgeries (please include dates): (Non-Spinal)

_____

_____

26. Please check any of the following problems that you have had: (❑ NONE)

❑ Heart disease or heart attack	❑ Rheumatic disease	❑ Dizziness
❑ High blood pressure	❑ Arthritis	❑ Loss of consciousness
❑ Asthma	❑ Swelling in toe or finger joint(s)	❑ Fainting
❑ Bronchitis/emphysema	❑ Neck problems	❑ Headaches
❑ Stomach ulcers	❑ Shoulder problems	❑ Difficulty concentrating
❑ Hepatitis	❑ Pain between shoulder blades	❑ Difficulty with memory
❑ Kidney infections	❑ Upper extremity problem	❑ Difficulty falling asleep
❑ Kidney stones	❑ Leg problem	❑ Difficulty staying asleep
❑ Prostatic problems	❑ Painful joint(s)	❑ Feeling tired in the morning
❑ Change in ability to pass urine	❑ Stiff joint(s)	❑ Unexplained weight loss
❑ Difficulty in bowel movements	❑ Broken bones	❑ Night sweats
❑ Urine incontinence	❑ Walking problem	❑ Fever
❑ Bowel incontinence	❑ Balance problem	❑ Difficulty swallowing
❑ Diabetes	❑ Seizure disorder	❑ Cancer _____
❑ Thyroid disease	❑ Tuberculosis	❑ Other _____

27. Please list any other medical problems not listed above:

_____

_____

28. What is or was your occupation? _____

29. Please describe your job description: _____

_____

_____

30. Are you currently working? ❑ YES ❑ NO ❑ RETIRED

31. Date last worked: _____/_____/_____

32. What was the longest time you missed from work with your worst episode? _____

33. What was the longest amount of time you missed from work in the last 12 months? _____

34. If you are not working now, do you see yourself: (Check one or more)
    - ❑ Returning to the same job
    - ❑ Modifying your work
    - ❑ Changing jobs – different employer
    - ❑ Retraining or returning to school
    - ❑ Applying for early retirement or long-term disability benefits

35. Do you smoke or have you previously smoked cigarettes?
    ❑ YES ❑ NO _____ packs per day x _____ years Year quit _____

36. Do you drink alcoholic beverages? ❑ YES ❑ NO How much per week? _____

37. Do you drink caffeinated beverages? ❑ YES ❑ NO How much per week? _____

38. What sports do you play?

_____

_____

39. Which activities and/or sports have you been unable to do since your symptoms began that you need or want to get back to?

_____

_____

40. Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed?

41. How many children do you have? _____ Age of the oldest – youngest?_____

42. What is your educational level?
❑ Grade School ❑ High School ❑ College (❑ 2-year or ❑ 4-year) ❑ Post college _____

43. Do you have anyone with a disability in your home? ❑ YES ❑ NO

44. Do you have a family history of:

❑ Back problems

❑ Arthritis

❑ Rheumatologic problems

❑ Neurologic problems (i.e., Multiple Sclerosis, other) _____

❑ Cancer (list family relationship and type of cancer) _____

❑ Other _____

Thank You!