Dear Patient,

In order to provide you with comprehensive spine care, we ask that you a take a few minutes to complete the questionnaire below. If you need help completing this form, please ask one of our office staff to assist you.

Your Name:____ **DOB:**_____________ **Age:**_________

If a doctor referred you to our office, what is his/her name? ____________________________

Current History

What is the main reason for your visit today? (Please check all that apply.)

❑ Back pain ❑ Leg pain ❑ Neck pain ❑ Arm pain

How long has this been a problem? (Please check the most accurate time period.)

❑ Less than 2 months ❑ 2-6 months ❑ 6-12 months ❑ Greater than 1 year

Have you been treated by any other medical provider for this condition?

If yes, please list name of provider:____

What treatments have you had for this problem? (Please check all that apply.)

❑ Nothing ❑Chiropractic Care ❑ Acupuncture ❑ Injections ❑ Physical Therapy

❑ Pain Medications If so, which medications? ____

Have you had any tests for this problem? (Please check all that apply.)

❑ None ❑ X-Ray ❑ MRI ❑ CT ❑ EMG ❑ Bone Scan

❑ CT Myelogram ❑ Discography ❑ Other (please specify)______________________________

Did your current spine problem result from any of the following? (Please check all that apply.)

❑ No Apparent Cause ❑ Car Accident ❑ Work Injury ❑ Sports Injury

❑ Other (Please Specify)____

How did your current problem begin? (Please check all that apply.)

❑ Suddenly ❑ Gradually ❑ Lifting ❑ Twisting ❑ After falling

❑ Bending ❑ Pulling ❑ Other (please specify)____

What makes your pain worse? (Please check all that apply.)

❑ During Exercise ❑ After Exercise ❑ Prolonged Sitting ❑ Prolonged Standing ❑ Walking

❑ Bending Forward ❑ Bending Backward ❑ Pushing ❑ Pulling ❑ Squatting ❑ Sleeping/night

❑ Other (please specify)____

What reduces your pain? (Please check all that apply.)

❑ Nothing ❑ Lying Down ❑ Sitting ❑Standing ❑ Walking ❑ Shifting/Changing positions

❑ Medication, which one(s)?________________________ ❑ Other (please specify) _________________

Past Medical/Surgical History

Have you previously undergone Spine Surgery?

❑ No ❑ Yes (please specify type(s) and date(s) of surgery)____________________________________

Have you previously undergone any other surgery? ❑ No ❑ Yes (If yes, please list below.)

Date	Surgery

Do you have any medical problems such as diabetes, high blood pressure, high cholesterol? Please list below.

Date	Medical Problem or Hospitalization

Are you allergic to any medications? ❑ No ❑ Yes (please specify medications and reactions below)

____

____

____

Are you allergic to latex? ❑ No ❑ Yes

Current Medications

Please list your medications in the table below.

Name of Medication	Strength	Number of pills per day

Social History

What is your occupation/vocation/profession?_______________________________________

Which of the following best describes your work status?

❑ Full time ❑ Part time ❑ Unemployed ❑ Disabled ❑ Retired

Do you currently smoke? ❑ No ❑ Yes How many packs per day?______________________

Did you previously smoke? ❑ No ❑ Yes When did you quit?___________________________

Do you use any other nicotine products? ❑ No ❑ Yes (please specify)____________________

How frequently do you drink alcohol?

❑ Never ❑ Daily ❑ 1-2 beverages/week ❑ 1-2 beverages/month ❑ 1-2 beverages/year

Are you currently involved or considering involvement in any type of litigation? Please specify below.

❑ Lawsuit ❑ Workers Comp. ❑ Disability Claim ❑ Social Security Claim ❑ Other__________

Family History

Do you have a family history of any of the following?

Arthritis	❑ Yes ❑ No	Blood Clots ❑ Yes ❑ No
Hypertension	❑ Yes ❑ No	Diabetes ❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Cardiac Disorders ❑ Yes ❑ No
Mental Health Disorders	❑ Yes ❑ No	Adverse reaction to Anesthesia ❑ Yes ❑ No
Excessive Bleeding	❑ Yes ❑ No	Other (please specify)________________________

Review of Systems

Do you currently or have you previously had problems with any of the following? Please describe all "Yes" answers.

Skin ❑ No ❑ Yes____

Ears, Nose, Throat ❑ No ❑ Yes____

Heart ❑ No ❑ Yes____

Lungs ❑ No ❑ Yes____

Stomach or Gastrointestinal ❑ No ❑ Yes____

Bladder or Bowel Problems ❑ No ❑ Yes____

Bleeding or Clotting Problems ❑ No ❑ Yes____

Diabetes ❑ No ❑ Yes____

Cancer ❑ No ❑ Yes____

Bone or Joint Problems ❑ No ❑ Yes____

Brain, Spinal Cord, or Nerve Problems ❑ No ❑ Yes____

Mental Health Problems ❑ No ❑ Yes____

Reproductive or Sexual Problems ❑ No ❑ Yes____

Fevers or chills ❑ No ❑ Yes____

Night Pain ❑ No ❑ Yes____

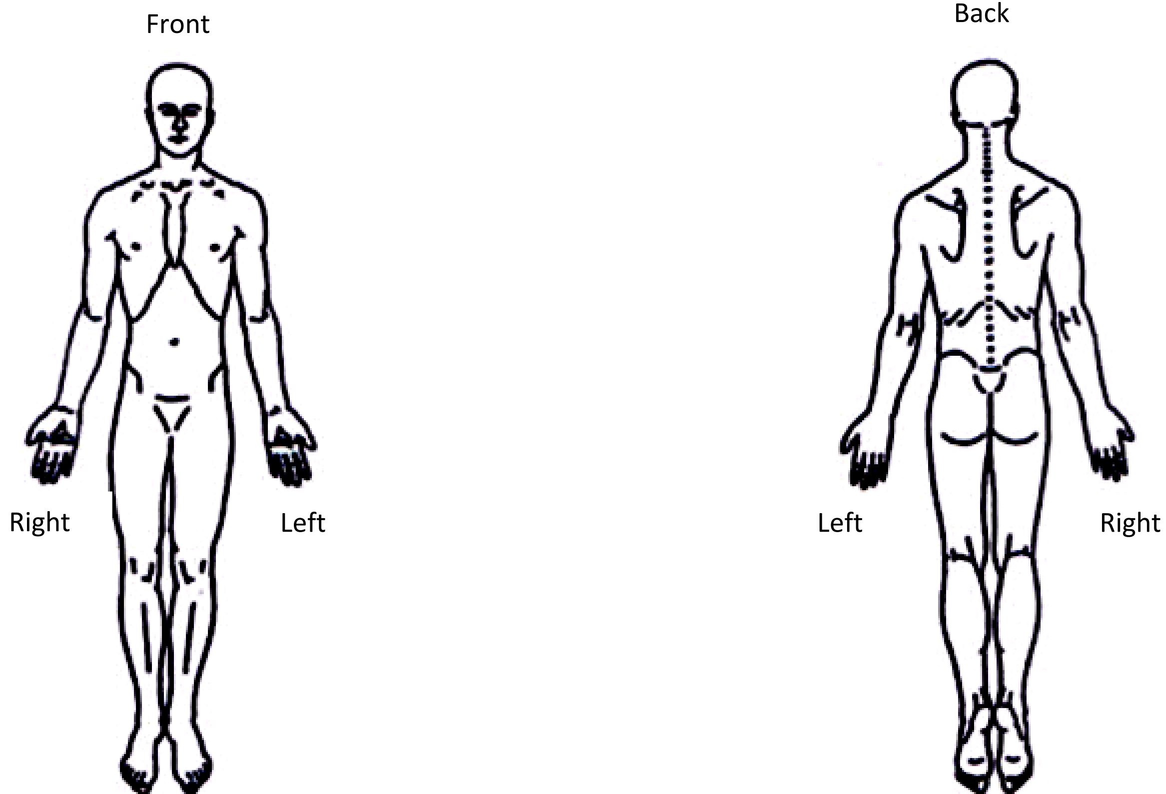
Unexpected Weight Loss ❑ No ❑ Yes____

Reviewed By:_______________________________________ Date:________________________

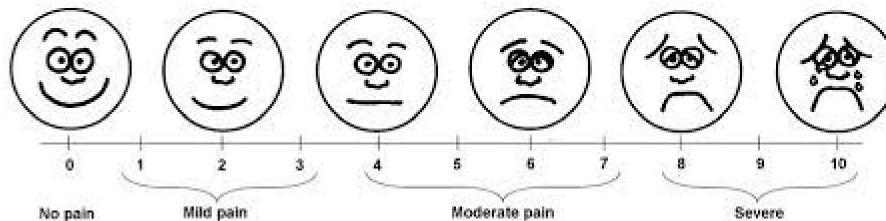
Pain Diagram

Where is your pain located? Please draw on the body diagrams below to show where you feel the sensations listed in the table. Use the symbols in each category to help indicate the type of pain you are having. Please feel free to provide further detail regarding your pain.

Ache	Numbness	Burning	Stabbing	Pins and Needles
AAA	OOO	XXX	///	- - -



Please use the pain scale below to answer the following questions.



On a scale from 0-10, how would you rate your pain at this moment? ____________________________

On a scale from 0-10, how would you rate your pain on your worst day?____________________________

On a scale from 0-10, how would you rate your pain on your best day? ____________________________