

CENTER FOR SPINE CARE PATIENT QUESTIONNAIRE

Name _____ Age _____ Sex _____

Referring Physician _____ Primary Care Physician (PCP) _____

Physician who should receive info regarding my care in the Center for Spine Care: referring referring & PCP none

Are you: Right handed Left handed Ambidextrous - use both hands equally

CHIEF COMPLAINT:

Do you have? (check all that apply) Neck pain Shoulder pain Arm pain Upper back pain
 Low back pain Hip/Leg pain Any other complaints _____

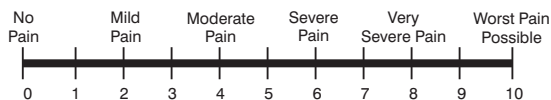
If more than one area, which is worse? _____

How long have you had this problem? _____

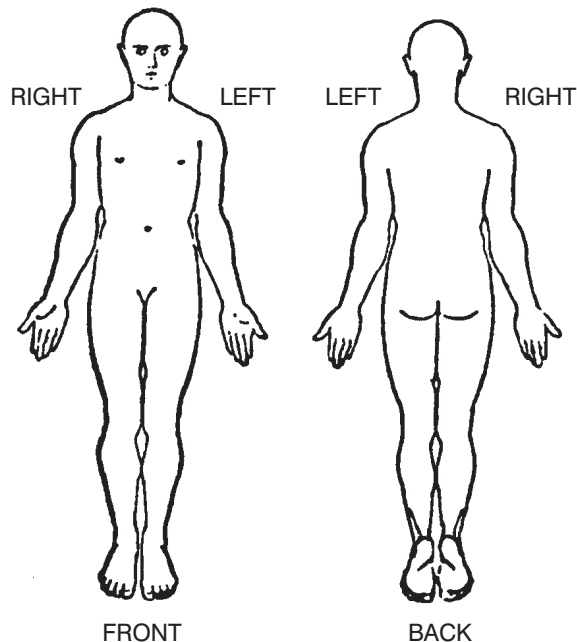
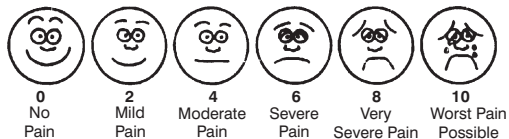
Did your symptoms follow an injury? Yes No If yes: at work auto accident other

Describe: _____

Circle a number from 0 to 10 that best describes your pain at its best, and at its worst.



Circle the face that best describes how you feel



LEGEND:

PAIN DRAWING - VERY IMPORTANT!

Show by marking and drawing on the front and back of the figures where you are having any:

- XXX Aching and/or pain
 - OOO Numbness and/or tingling
 - Pins and/or needles
 - /// Burning
 - ΔΔΔ Spasms and/or cramps
- (Draw arrows (→) or indicate where pain goes or shoots. Show all areas involved). Please mark or indicate where the pain is **worse now**.

Describe your pain (check all that apply) Constant Deep Dull Sharp Intermittent
 Throbbing Stiffness Aching Shooting Cramping Burning Stabbing



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Indicate which of the following activities increase (I) or decrease (D) your pain

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> When I first get out of bed | <input type="checkbox"/> Standing | <input type="checkbox"/> Bending back | <input type="checkbox"/> Lying on my back/side |
| <input type="checkbox"/> Lifting/bending forwards | <input type="checkbox"/> Sitting | <input type="checkbox"/> Straining | <input type="checkbox"/> Leaning forward |
| <input type="checkbox"/> Look up/turn head sideways | <input type="checkbox"/> Coughing/Sneezing | <input type="checkbox"/> Walking | <input type="checkbox"/> Reaching over |
| <input type="checkbox"/> Going down stairs/ramp | <input type="checkbox"/> Long car rides | <input type="checkbox"/> Lying on Stomach | <input type="checkbox"/> Washing/combing hair |
| <input type="checkbox"/> Climbing stairs/walking up ramp | <input type="checkbox"/> Twisting | <input type="checkbox"/> Other | |

Pain and Sleep

- | | | | |
|-----------------------------|--|------------------------------------|---------------------------------------|
| Trouble falling asleep: | <input type="checkbox"/> Almost Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Almost Never |
| Medication needed to sleep: | <input type="checkbox"/> Almost Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Almost Never |
| Awakened by pain: | <input type="checkbox"/> Almost Always | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Almost Never |

Please indicate previous tests you have had for this problem:

| Date | Location | Date | Location |
|-----------------|----------|-------------------|----------|
| MRI _____ | | CT Scan _____ | |
| Myelogram _____ | | Bone Scan _____ | |
| EMG _____ | | X-rays _____ | |
| Discogram _____ | | Lab Studies _____ | |

Circle the medications you use, or have used to manage your pain.

- Anti-inflammatory medications: Ibuprofen, Naprosyn, Vioxx, Celebrex, Relafen, Bextra, other _____
- Muscle relaxant medications: Flexeril (Cyclobenzaprine), Skelaxin, Zanaflex (Tizanidine), other _____
- Anti-depressant medications _____ Narcotic pain medications _____
- Other: _____

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for your problem in the past. Then check the column that best describes the effect of the treatment.

| Treatment | Better | Worse | No change | Treatment | Better | Worse | No change |
|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Hot packs/ice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Massage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pool therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> TENS/Electrical Stim | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Yoga/Tai-Chi | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Trigger point injections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Exercises | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Braces/Splints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Traction/DRS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Medication(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bed Rest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chiropractic Adjustments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Work Hardening | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Epidural Steroid Injection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Pain Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> Hypnosis for pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What activities would you like to do that your pain keeps you from doing? _____

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REVIEW OF SYSTEMS:

| | | | | | | | | |
|-------------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| Constitutional | | | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Blood in Stool | <input type="checkbox"/> | <input type="checkbox"/> |
| Chills | <input type="checkbox"/> | <input type="checkbox"/> | Palpitations/Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Weight Change | <input type="checkbox"/> | <input type="checkbox"/> | Leg Swelling | <input type="checkbox"/> | <input type="checkbox"/> | Change in Bowel Habits | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Rate | <input type="checkbox"/> | <input type="checkbox"/> | GU | | |
| Weakness | <input type="checkbox"/> | <input type="checkbox"/> | Coldness/Discoloration | <input type="checkbox"/> | <input type="checkbox"/> | Pain with Urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | of Extremities | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Disturbance | <input type="checkbox"/> | <input type="checkbox"/> | Calf Pain | <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat/Cold Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | Skin | | | Dribbling/ Urgency/ | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Thirst/Hunger | <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | Frequency | | |
| HEENT | | | Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Sexual Difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | Neurological | | | Pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual Disturbance | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness /Vertigo | <input type="checkbox"/> | <input type="checkbox"/> | LMP _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss/Ringing | <input type="checkbox"/> | <input type="checkbox"/> | Tremors | <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal | | |
| Nose Bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Spasms | <input type="checkbox"/> | <input type="checkbox"/> | Joint Stiffness/Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemo-lymphatic | | | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain/Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Atrophy | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Cramps | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> | Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | History of Fracture | <input type="checkbox"/> | <input type="checkbox"/> |
| Lymph Node Swelling | <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine | | |
| Allergy/Immune | | | Frequent/Severe headaches | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine Allergy | <input type="checkbox"/> | <input type="checkbox"/> | GI | | | Psychological | | |
| CV/Respiratory | | | Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/Panic Attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss/Confusion | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Constipation | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PAST MEDICAL HISTORY: Please place a check mark next to the conditions that apply.

| | | | | | | | | | | | |
|-------------------|--------------------------|--------------------------|------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| | Your History | Family History | | Your History | Family History | | Your History | Family History | | Your History | Family History |
| Addison's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | TB | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV + | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve | | | Thyroid | | |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Polio | <input type="checkbox"/> | <input type="checkbox"/> | Kidney | | |
| Bladder | | | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric | | | Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Infections | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Problems | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding/Clotting | | | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Resp/Breathing | | | Any other disease | | |
| Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Problems | <input type="checkbox"/> | <input type="checkbox"/> | (Please list): | | |
| Blood or Plasma | | | High Blood | | | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Stomach | | | _____ | | |
| Cancer-Location | <input type="checkbox"/> | <input type="checkbox"/> | Hives or Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Chickenpox/ | | | Infectious Mono | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Others: | <input type="checkbox"/> | <input type="checkbox"/> |
| Shingles | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| Chronic Headaches | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |

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MEDICATIONS: List all current medications including over-the-counter medications.

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|------------|------|-----------|------------|------|-----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

ALLERGIES TO MEDICATION:

| Medication | Reaction | Medication | Reaction |
|------------|----------|------------|----------|
| | | | |
| | | | |

Other (such as Hayfever, etc.) _____

Smoker? Yes No If yes, how long? _____ How much? (packs/day) _____

Did you quit? Yes No If yes, how long ago? _____ If yes, how much per day / week / month? _____

Do you consume alcoholic beverages? Yes No What type? _____ How many per week? _____

*MARITAL statuses: Single Married Divorced Widowed

CHILDREN? Yes No

*HIGHEST education level completed:

Less than High School High School College

Graduate School Vocational / technical

Are you presently employed? Yes No How long have you been there? _____

Do you like your work? Yes No If no, why not? _____

Present occupation: _____ Prior occupation: _____

Your activities at work or home mostly involve:

- Manual labor, heavy lifting most of the day
- Walking or standing most of the day
- Sitting most of the day
- House and child care
- Manual labor, less strenuous
- Other; please explain: _____

Past Surgeries

| Date | Surgery | Physician | Hospital |
|------|---------|-----------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

WAUKESHA MEMORIAL HOSPITAL
ORIGINAL - Medical Records

PATIENT LABEL

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CENTER FOR SPINE CARE PATIENT QUESTIONNAIRE

Is your work too heavy or hard? Yes No If yes, why? _____

If employed, are you off work now? Yes No N/A (Does not apply)

If you are not working, is it because of neck or back pain? Yes No

If yes, when was it you last worked? (Give date): _____

Are you collecting disability? Yes No

Is there pending litigation or ruling involving your injury/condition? Yes No

"Because violence is so common in many people's lives, we ask this question of all patients."

"In the last year has anyone harmed you or threatened you?" Yes No

Do you have a signed donor card? Yes No

Do you have advanced directives in place. Yes No N/A, under 18 years old

If not, would you like information? Yes No

Patient Signature: _____ Date: _____

Date Updated/Initial _____ Date Updated/Initial _____

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