NEW PATIENT QUESTIONNAIRE
Center for Spine Care

Rev. Sept. 2014

Name: ____________________________ Date of Visit: _________________________

Male O Female O

Date of Birth: ____________________

Height: __________ Weight: __________

Age Today: ______________________

*Please note this is a multi-part questionnaire. When you are done, please take a moment to go over the questionnaire to be sure you have not missed any pages or questions. Thank you for your help.

1. Pain Drawing: Mark these drawings using the symbol that best describes your pain quality.
   - Numbness ====
   - Ache ^^^^^
   - Stabbing /-----
   - Burning XXXX
   - Cramping ++++
   - Pins & Needles O O O O

3. If you have BACK pain...
   
   _____% back pain + _____% leg pain = 100%
   On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

   Back
   - 0 1 2 3 4 5 6 7 8 9 10 Worst
   - None O O O O O O O O O O Pain
   - Circle one: occasional | intermittent | frequent | constant

   Leg
   - 0 1 2 3 4 5 6 7 8 9 10 Worst
   - None O O O O O O O O O O Pain
   - Circle one: occasional | intermittent | frequent | constant

4. If you have NECK pain...
   
   _____% neck pain + _____% arm pain = 100%
   On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

   Neck
   - 0 1 2 3 4 5 6 7 8 9 10 Worst
   - None O O O O O O O O O O Pain
   - Circle one: occasional | intermittent | frequent | constant

   Arm
   - 0 1 2 3 4 5 6 7 8 9 10 Worst
   - None O O O O O O O O O O Pain

2. Which area is most painful?
   - O Low back and/or legs
   - O Neck and/or arms
   - O Both are equal
   - O Pelvis / Buttock Pain
   - O Hip / Groin Pain
6. What is the primary reason for your visit?
   ○ Evaluation/ Diagnosis/ Treatment
   ○ Second opinion
   ○ Education/ information
   ○ Surgical planning

7. How did your current symptoms begin?
   ○ Suddenly       Date: _____________
   ○ Gradually

   Please describe: ____________________________________________
   ____________________________________________
   ____________________________________________

8. How long ago did your current symptoms begin?
   ○ Less than 2 weeks ago
   ○ 3 months to less than 6 months ago
   ○ 2 weeks to less than 8 weeks ago
   ○ 6 to 12 months ago
   ○ 8 weeks to less than 3 months ago
   ○ More than 12 months ago

9. Is this a work-related injury?
   ○ Yes      ○ No

10. Have you ever filed a Worker’s Compensation claim for your back/ neck symptoms in the past?
    ○ Yes     ○ No

    If yes, Date: _____________

11. Did your pain begin after a car accident?
    ○ Yes      ○ No (skip to question #12)

    If you were injured in a car accident please carefully fill out the questions below.

    Date of Accident: _____________

    Briefly describe the details of the accident:

    ____________________________________________
    ____________________________________________
    ____________________________________________

    Describe the pattern of symptoms over the first 1-4 weeks:
When did you first notice symptoms?
- Immediately
- 1-2 weeks
- 24-28 hours
- 2-4 weeks
- 3-7 days
- > 1 month

When did you first report these to a doctor?

If there was a delay between the symptoms starting and your first report, please explain:

Did you suffer any other injuries when you hurt your spine?
- Yes
- No

If yes, please list:

12. Have you ever been involved in a previous car accident?
- Yes
- No

If yes, approximate date:

Was your back or neck injured?
- Yes
- No

If yes, did the injury resolve?
- Yes
- No

If that injury did NOT resolve, what treatment, if any, did you require on an ongoing basis?

Explain:

13. Is your pain due to an injury not covered in the questions above?
- Yes
- No

If yes, Date of injury:

Describe injury:

14. Have you ever had previous back or neck surgery?
- Yes
- No

If yes, how many surgeries?

<table>
<thead>
<tr>
<th>Date of Spine surgery</th>
<th>Type of surgery</th>
<th>% Improvement</th>
<th>How long did the improvement last?</th>
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18. Modified Oswestry Disability Index: This questionnaire has been designed to give your doctor information as to how your pain as affected your ability to manage in everyday life. Please answer every question marking the ONE box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but please mark only the box that most closely describes your current condition.

**Pain Intensity**
- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medication has no effect on my pain.

**Personal Care (e.g., Washing, Dressing)**
- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

**Lifting**
- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

**Walking**
- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

**Sitting**
- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

**Standing**
- I can stand as long as I want without increased pain.
- I can stand as long as I want, but it increases my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 1/2 hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

**Sleeping**
- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

**Social Life**
- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from forms going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

**Traveling**
- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under 1/2 hour.
- My pain prevents all travel except for visits to the physician/therapist or hospital.

**Employment / Homemaking**
- My normal homemaking / job activities do not cause pain.
- My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.
To insure that your medical report is sent to the individual(s) that you request, please provide us with the information below, including FAX number(s). Without all of this information, we cannot send the report.

I authorize the Group to release my medical reports to the individual(s) as specified below. By signing below understand that this information will not be sent unless requested by myself.

ATTORNEY’s Name: _______________________________ Phone: __________________
Address: _______________________________________

ATTORNEY’s FAX Number: _________________________

PRIMARY and/or
REFERRING CARE PHYSICIAN: ______________________ Phone: __________________
Address: _______________________________________

PRIMARY and/or REFERRING CARE PHYSICIAN FAX Number: ______________________

OTHER: _________________________________________ Phone: __________________
Address: _______________________________________

OTHER FAX Number: _____________________________

Patient’s Signature: ______________________________

Please Print Name: ______________________________

Patient Number: _______________________________