Name_____ Date_____

# Spine Patient Questionnaire

1. Age _____
2. What do you do for a living? _____
3. If you could have treatment directed at the pain in only **ONE** area, which would it be?

   Neck OR Arm(s) OR Low Back OR Leg(s)
4. When did your symptoms start? _____
5. What have you done so far for your symptoms? (oral medications, physical therapy, injections, etc.)

   _____
6. Please list all **Spine (Neck and Back)** procedures, injections, and surgeries below.

| Month/Year | Procedure | Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

7. Over the past month, please rate the pain in your:

| | None | Minimal | | Mild | | Moderate | | Severe | | Excruciating |
|---|---|---|---|---|---|---|---|---|---|---|
| Neck | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Left Arm | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Right Arm | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | | | |
| Low Back | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Left Leg | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Right Leg | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Name_____ Date_____

8. Have you noticed that you are **Dropping** things or that your hands feel clumsy? Yes No
9. Have you felt more **Off-balance** or unsteady on your feet? Yes No
10. Do you feel **Weakness** in one or both of your arms or hands? Yes No
11. Do you feel **Numbness** or tingling in one or both of your arms or hands? Yes No

12. Have you ever had any type of cancer? Yes No
13. Do you have pain at night that causes you to be unable to fall back asleep? Yes No
14. Have you recently had an unexplained fever? Yes No
15. Have you ever been diagnosed with osteoporosis? Yes No
16. Have you ever used corticosteroids for a prolonged duration? Yes No
17. Within the past 30 days, have you been involved in significant trauma (fall, car crash, etc.)? Yes No
18. Have you had a recent onset of urinary or bowel incontinence or inability to urinate at all even when you have a full bladder? Yes No
19. Have you had a recent onset of numbness and/or tingling in your genitalia, anus, or perineum? Yes No
20. Do you have progressive weakness in one or both of your legs? Yes No

21. Over the past two weeks, how often have you been bothered by any of the following problems?
    A. Little interest or pleasure in doing things

       Not at all OR Several days OR More than one-half the days OR Nearly every day
    B. Feeling down, depressed, or hopeless

       Not at all OR Several days OR More than one-half the days OR Nearly every day

22. What activities would you like to do that your condition prohibits you from doing?

_____

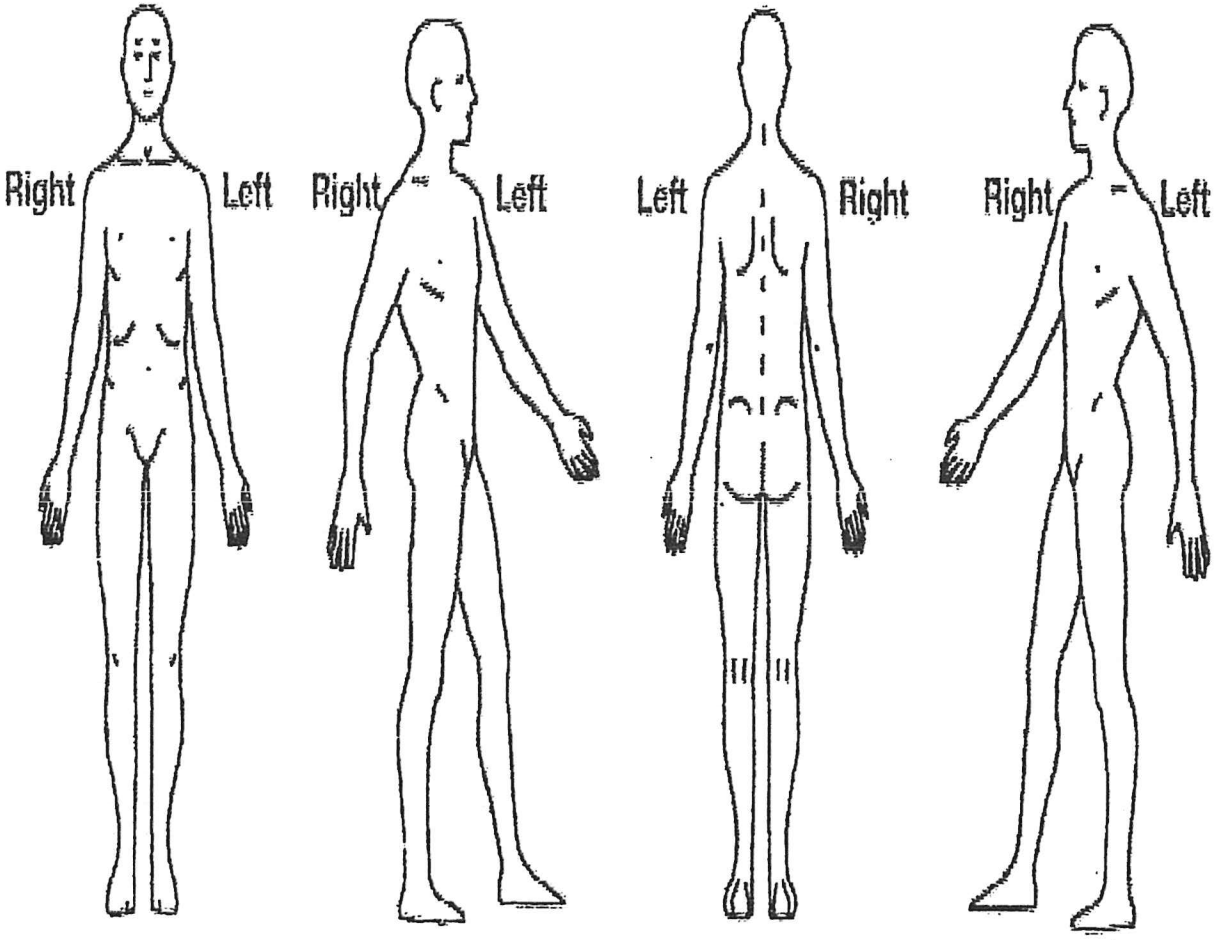
_____

BLUE RIDGE
ORTHOPAEDIC &
SPINE CENTER

Name_____Account #_____

Date_____

PAIN DIAGRAM: Please outline the area where you have pain



Patient Name: _____ Appointment Date: _____/_____/_____

Account #: _____

**Review of Systems:** Please check [ √ ] any of the following symptoms you are having:

| Constitutional | Integumentary | Neurological |
|---|---|---|
| ☐ unexplained weight loss: _____lbs. | ☐ rashes | ☐ headache |
| ☐ unexplained weight gain: _____lbs. | ☐ frequent bruising | ☐ blackouts and fainting |
| ☐ night sweats | ☐ hives | ☐ tingling / numbness |
| ☐ fevers/chills | ☐ sores that don't heal | ☐ paralysis |
| ☐ loss of appetite | ☐ NONE | ☐ seizures |
| ☐ NONE | | ☐ memory loss |
| | | ☐ NONE |
| **Eyes** | **Cardiovascular** | **Ear/Nose/Throat** |
| ☐ blurry vision | ☐ chest pain/pressure/tightness | ☐ vertigo/dizziness |
| ☐ double vision | ☐ palpitations | ☐ ringing in the ear |
| ☐ eye pain | ☐ trouble breathing while lying | ☐ nose bleed |
| ☐ NONE | ☐ NONE | ☐ sinusitis |
| | | ☐ trouble swallowing |
| | | ☐ hearing aid |
| | | ☐ NONE |
| **Respiratory** | **Psychological** | **Gastrointestinal** |
| ☐ shortness of breath | ☐ depression | ☐ stomach pain/heart burn |
| ☐ COPD | ☐ anxiety | ☐ bloody or dark stools |
| ☐ chronic cough | ☐ NONE | ☐ constipation |
| ☐ NONE | | ☐ diarrhea |
| | | ☐ nausea/vomiting |
| | | ☐ NONE |
| **Musculoskeletal** | **Genitourinary** | |
| ☐ joint pain | ☐ blood in the urine | |
| ☐ joint redness and swelling | ☐ painful urination | |
| ☐ leg pain with walking | ☐ urgency to urinate | |
| ☐ muscle cramps | ☐ loss of bladder control | |
| ☐ weakness | ☐ frequent urination | |
| ☐ NONE | ☐ difficulty urinating | |
| | ☐ NONE | |

I acknowledge, I have reviewed the above information and have completed the form to the best of my ability.

_____ _____

Patient Signature M.D. Signature

**For Clinical Use only**

Ht. _____ Wt. _____ B/P _____ P _____ BMI:_____