SPINE CENTER NEW PATIENT QUESTIONNAIRE

Primary Care Physician’s Name __________________________________________ Fax ________________

Who referred you to the Spine Center? __________________________________________________________

Your age ________ Right handed ________ Left handed ________

If you are having pain, where are your symptoms located? (check all that apply)

<table>
<thead>
<tr>
<th>Area</th>
<th>No Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 Severe Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
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<tr>
<td>Right Arm</td>
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<td>Mid Back</td>
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<td>Low Back</td>
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<td>Right Leg</td>
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<td>Left Leg</td>
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</tr>
</tbody>
</table>

Are you experiencing:

Arm or leg numbness ___ No ___ Yes
Arm or leg weakness ___ No ___ Yes
Bladder problems ___ No ___ Yes
Pain with walking ___ No ___ Yes If Yes, how many minutes can you walk? _______________________

When did your symptoms begin? ___/___/___

Were you injured at work? ___ No ___ Yes Date __________________

Were you injured in a motor vehicle accident? ___ No ___ Yes Date __________________

Can you recall a specific event associated with the onset of your symptoms? ___ No ___ Yes

If yes, describe? ________________________________________________________________

(This space for Doctor’s only) __________________________________________________________

NAME: __________________________________________ DATE: _______________________

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Have you ever had pain or problems in these areas before? ___No     ___Yes

Have you had any prior spine surgery? ___No     ___Yes     If yes, how many operations?____

Have you had any diagnostic test? (Please bring all diagnostic studies and reports for your Spine Center Visit.)
___X-Rays
___MRI
___CT Scan

Are you currently taking any medications for your pain symptoms? (List only medications used for pain.)
Name  Dosage  Does it help?  Side Effects?

Have you had any of the following treatments for your symptoms? (Please Check)
___Physical therapy
___Chiropractic
___Acupuncture
___Epidural Injections
___Facet Injections
___Nerve root blocks
___Other treatments

In an average week, how often do you:
Stretch your back or neck?  Never  1  2  3  4  5 or more
Exercise your back or neck?  ____  ____  ____  ____  ____  ____
Lift weights for your back or neck?  ____  ____  ____  ____  ____  ____
Perform aerobic exercises?  ____  ____  ____  ____  ____  ____

What is your current work status?
___Not working because of pain
___Working but reduced hours or intensity because of pain
___Working to desired capacity despite pain
___Disabled from working because of other health problems
___Unemployed, but looking for work
___Unemployed, by choice/ Homemaker
___Retired
___Student

If you are out of work, for how long?____What is your occupation or profession? ____________

Include elementary, high school, college, etc, how many years of school have you attended? ____

Because of your pain, are you currently receiving:
Workers’ Compensation ___ No ___ Yes ___ Applying for workers’ compensation
Social Security Disability ___ No ___ Yes ___ Applying for social security disability benefits
Private Disability ___ No ___ Yes ___ Applying for private disability benefits

Have you hired a lawyer to help with you legal issues concerning your pain? ___No     ___Yes
Are you involved in a personal injury lawsuit because of your pain? ___No     ___Yes     Unsure
This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 – Pain Intensity
☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it is very painful.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day is most aspects of self care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they 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.

Section 4 – Walking
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than 100 yards.
☐ I can only walk with a cane or crutches.
☐ I am in bed most of the time and have to crawl to the bathroom.

Section 5 – Sitting
☐ I can sit in any chair as long as I like.
☐ I can 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 ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 – Standing
☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than ½ hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 – Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturbed by pain.
☐ Because of pain I have less than 6 hours sleep.
☐ Because of pain I have less than 4 hours sleep.
☐ Because of pain I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)
☐ My sex life is normal and causes no extra pain.
☐ My sex life in normal and causes some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex at all.

Section 9 – Social Life
☐ My social life is normal and causes me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. sports, etc.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 10 – Traveling
☐ I can travel anywhere without pain.
☐ I can travel anywhere but it gives extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary journeys less than 30 minutes.
☐ Pain prevents me from travelling except to receive medical treatment.

Score _________/_________ = _________%
Please circle “Y” of “N” if you currently have the problem in the first column. *If you do not have the problem, skip to the next problem.* If you do have the problem, please indicate in the second column if you receive medications or some other type of treatments for the problem, and list them in the third column. Then in the fourth column, indicate if the problem limits any of your daily activities. Finally, at the end please list all additional medical conditions and daily medication.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Do you have the problem?</th>
<th>Do you receive treatment for it</th>
<th>List medications or treatment</th>
<th>Does it limit your activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Lung disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Ulcer or stomach disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Liver disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Anemia or other blood disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Cancer, Type [ ] Date of Diagnosis [ ]</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Depression / Anxiety</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Osteoarthritis [ ] (degenerative arthritis other than spine)</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Chronic pain in other areas Where [ ]</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>List other medical problems and daily medications</td>
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<tr>
<td>___________________________</td>
<td>Y</td>
<td>N</td>
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<td>Y</td>
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<tr>
<td>___________________________</td>
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<td>Y</td>
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<tr>
<td>___________________________</td>
<td>Y</td>
<td>N</td>
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<td>Y</td>
</tr>
</tbody>
</table>

Do you regularly take Aspirin? _____ Blood thinners?_____ Anticoagulants? ________
Have you ever been hospitalized for a medical or psychiatric illness? __________________________

Please list any surgeries _____________________________________________________________

Please list all allergies to medications _______________________________________________

Do you use tobacco? ___ No ___ Yes Packs per day _____ Total Years _______________

Do you drink alcohol? ___ No ___ Yes How many drinks per week? ______________________

Marital status _______ Children _____________ Grandchildren __________

Hobbies and non-work activities ______________________________________________________

Have you ever felt unsafe at home? ___ No ___ Yes

Have you ever been harmed (hit) or threatened by someone close to you? ___ No ___ Yes

Is there anything occurring in your family or home life which is upsetting you? ___ No ___ Yes

What is your height? ___________ Weight? ___________

Do you have any of the following problems? (Please check)

- Headaches
- Seizures, Stroke, Brain Injuries
- Loss of concentration, memory problems
- Visual or hearing impairments, glaucoma
- Loss of coordination, tremor, balance problems
- Asthma or respiratory problems
- Chest pain, heart diseases, hypertension, murmurs, arrhythmias
- Elevated cholesterol
- Abdominal pain
- Stomach problems, ulcers, hiatal hernias
- Colitis, irritable bowel, digestive problems
- Hepatitis or liver disease
- Diabetes
- Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis

- Date of last bone density _______________________
- Kidney, urine or bladder problems
- Pelvic pain

Does anyone in your family have a history of:

- Heart disease
- Cancer
- Neuropathy of Neurological problems
- Arthritis
- Cancer
- Recent fever, chills, night sweats
- Prolonged, persistent or recent infection
- Bleeding tendencies
- Blood clots, phlebitis
- Anemia or blood disorders
- Thyroid or other hormonal problem
- Loss of appetite
- Unexplained weight loss
- Depression
- Anxiety
- Stress

(For Women)
- Menstrual difficulty or possibility of pregnancy
- Abnormal Pap smear
- Abnormal mammography

(For Men)
- Prostate problem
- Abnormal PSA

- Disc herniation
- Spinal Stenosis
- Spine surgery
- Chronic pain
- Scoliosis

X ___________________________ am / pm

Patient Signature                  Print Name                  Date                       Time
# SPINE CENTER NEW PATIENT QUESTIONNAIRE

## Cervical

<table>
<thead>
<tr>
<th>Flexion</th>
<th>Maximum (°)</th>
<th>Painless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Side Flexion</td>
<td>R____ L____</td>
<td>R____ L____</td>
</tr>
<tr>
<td>Rotation</td>
<td>R____ L____</td>
<td>R____ L____</td>
</tr>
</tbody>
</table>

### Palpation

- **Shoulder**
- **Elbow**

### Neurological

<table>
<thead>
<tr>
<th>Motor (Grade 1 - 5)</th>
<th>Sensory (Pin Prick)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biceps Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Pronator Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Triceps Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
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<tr>
<td>Intrinsic Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
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<tr>
<td>Adm Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
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</tbody>
</table>

### Reflexes

- **Biceps** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Triceps** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Finger** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Hoffman** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |

### Thoracic Spine

<table>
<thead>
<tr>
<th>Maximum (°)</th>
<th>Painless</th>
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<tbody>
<tr>
<td>Rotation Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Rotation Left</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
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</tbody>
</table>

### Lumbar (Standing)

<table>
<thead>
<tr>
<th>Maximum (°)</th>
<th>Painless</th>
</tr>
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<tbody>
<tr>
<td>Flexion</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Extension</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Side Flexion</td>
<td>R____ L____</td>
</tr>
</tbody>
</table>

### Root Tension Signs

- **Straight Leg Raising (°)**
- **Femoral Stretch**

### Neurological

<table>
<thead>
<tr>
<th>Motor (Grade 1 - 5)</th>
<th>Sensory (Pin Prick)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quad Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Dorsi Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
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<tr>
<td>E H L Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Hip ABD Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
<tr>
<td>Calif Right</td>
<td>_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _</td>
</tr>
</tbody>
</table>

### Reflexes

- **Patella** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Achilles** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Babinski** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Clonus** Right | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |

### Waddell

- **Over React** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Sup Tend** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Dis SLR** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Simul Rot** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Global** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |

**Scar:** ____________________  **Posture:** ____________________  **GaIt:** ____________________

**Vascular**

- **Right** | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Left** | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |

**Atrophy**

- **Right** | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
- **Left** | _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |

**Palpation**

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**Provider Signature / Credentials**

**Print Name**

**Date**

**Time (24 hours)**

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