Please complete and give to the receptionist when you arrive at the office for your appointment.

NAME: ____________________

DATE: ____________________

NEW ENGLAND BAPTIST HOSPITAL

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Primary Care Physician's Name ____________________

Primary Care Physician's Phone ____________________ **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)

Average pain intensity in the last week

Location	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Neck**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Right Arm**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Left Arm**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Mid Back**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Low Back**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Right Leg**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain
___**Left Leg**___________	No Pain 0	1	2	3	4	5	6	7	8	9	10 Severe Pain

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) ____________________

CL0200

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Date: __________________ Patient Name ______________________________________

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 and average week, how often do you:

	Never	1	2	3	4	5 or more
Stretch your back or neck?	_____	_____	_____	_____	_____	_____
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

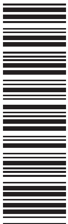
___ Unemployed, but looking for work

___ 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**

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Date: ________________ Patient Name ____

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 disturber 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.

(ODI 2.0)

Score ________/________=________%

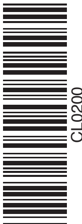
CL0200

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Date: ________________ Patient Name ______________________________________

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 of page list all additional medical conditions and daily medication.

PROBLEM	**Do you have the problem?**		**Do you receive treatment for it**		**List medications or treatment**	**Does it limit your activities**	
Heart Disease	Y	N	Y	N	________________ ________________	Y	N
High blood pressure	Y	N	Y	N	________________ ________________	Y	N
Lung disease	Y	N	Y	N	________________ ________________	Y	N
Diabetes	Y	N	Y	N	________________ ________________	Y	N
Ulcer or stomach disease	Y	N	Y	N	________________ ________________	Y	N
Kidney disease	Y	N	Y	N	________________	Y	N
Liver disease	Y	N	Y	N	________________	Y	N
Anemia or other blood disease	Y	N	Y	N	________________ ________________	Y	N
Cancer, Type__________ Date of Diagnosis ______	Y	N	Y	N	________________ ________________	Y	N
Depression / Anxiety	Y	N	Y	N	________________ ________________	Y	N
Osteoarthritis ________ (degenerative arthritis other than spine)	Y	N	Y	N	________________ ________________	Y	N
Chronic pain in other areas Where______________	Y	N	Y	N	________________ ________________	Y	N
Rheumatoid arthritis	Y	N	Y	N	________________	Y	N
Glaucoma	Y	N	Y	N	________________	Y	N



List other medical problems and daily medications

________________	Y	N	Y	N	________________ ________________	Y	N
________________	Y	N	Y	N	________________ ________________	Y	N
________________	Y	N	Y	N	________________ ________________	Y	N

Do you regularly take Aspirin? _____ Blood thinners?_____ Anticoagulants? ________

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Date: ________________ Patient Name ______________________________________

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

___ 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

Does anyone in your family have a history of:

___ Heart disease ______________________
___ Cancer ______________________
___ Neuropathy of Neurological problems_________
____
___ Arthritis ______________________

___ Disc herniation ______________________
___ Spinal Stenosis ______________________
___ Spine surgery______________________
___ Chronic pain______________________
___ Scoliosis ______________________

X______________________ ______________________ __________ ________ am / pm

Patient Signature Print Name Date Time

SPINE CENTER NEW PATIENT QUESTIONNAIRE

Date: ___________________ Patient Name ____

CERVICAL

	MAXIMUM (°)	PAINFUL
FLEXION	________	________
EXTENSION	________	________
SIDE FLEXION	R______ L______	R______ L______
ROTATION	R______ L______	R______ L______

PALPATION ____

	SHOULDER	ELBOW
RIGHT	________________	________________
LEFT	________________	________________

NEUROLOGICAL **MOTOR** (GRADE 1 - 5) **SENSORY** (PIN PRICK)

		MOTOR RIGHT	MOTOR LEFT	SENSORY RIGHT	SENSORY LEFT
C-5	BICEPS	________	________	________	________
C-6	PRONATOR	________	________	________	________
C-7	TRICEPS	________	________	________	________
C-8	INTRINSIC	________	________	________	________
T-1	ADM	________	________	________	________

REFLEXES	**BICEPS**	**BRACHIORADIALIS**	**TRICEPS**	**FINGER**	**HOFFMAN**
RIGHT	________	________	________	________	________
LEFT	________	________	________	________	________

THORACIC SPINE

	MAXIMUM (°)	PAINFUL
ROTATION RIGHT	________	________
ROTATION LEFT	________	________

DEFORMITY ____

LUMBAR (STANDING)

	MAXIMUM (°)	PAINFUL
FLEXION	________	________
EXTENSION	________	________
SIDE FLEXION	R______ L______	R______ L______

	HIP	KNEE
RIGHT	________________	________________
LEFT	________________	________________

ROOT TENSION SIGNS	STRAIGHT LEG RAISING (°)	PAIN
RIGHT	________	________________
LEFT	________	________________

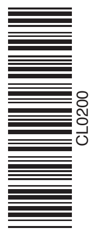
FEMORAL STRETCH

RIGHT ____

LEFT ____

NEUROLOGICAL **MOTOR** (GRADE 1 - 5) **SENSORY** (PIN PRICK)

	MOTOR RIGHT	MOTOR LEFT		SENSORY RIGHT	SENSORY LEFT
QUAD	________	________	L2	________	________
DORSI	________	________	L3	________	________
E H L	________	________	L4	________	________
HIP ABD	________	________	L5	________	________
CALF	________	________	S1	________	________



REFLEXES	**PATELLA**	**ACHILLES**	**BABINSKI**	**CLONUS**
RIGHT	________	________	________	________
LEFT	________	________	________	________

WADDELL _____ OVER REACT ___ SUP TEND___ DIS SLR ___ SIMUL ROT ___ GLOBAL ____

SCAR: ________________ POSTURE: ________________ GAIT: ________________

VASCULAR RIGHT ____

LEFT ____

ATROPHY RIGHT ____

LEFT ____

PALPATION ____

X________________________ ________________________ ____________ ____________

Provider Signature / Credentials | Print Name | Date | Time (24 hours)