SPINE PATIENT HISTORY QUESTIONNAIRE

Date:_____
Patient Name:_____
Primary Doctor:_____City:_____Phone #:_____
Referring Doctor:_____
Date of Birth:_____Age:_____
Occupation:_____Right /Left Handed

Description of the problem:

_____
_____
_____
_____

Duration of symptoms:_____
Do you have any bowel or bladder problems?_____
Do you have any difficulty with walking?_____
Do you drop objects, or have difficulty hand writing or fine manipulations? (such as buttoning a shirt)

_____
If so, has this changed recently? _____

If this is a workman's compensation claim, then please answer the following:
How did the injury occur?_____
When?_____
Where?_____
When was your supervisor notified?_____
If you were seen at an acute care / occupational health center – which one and where?
_____ _____

Have you ever had a similar problem in the past? (If so how was it treated, did it resolve, etc.)

_____
_____

Have you had any treatments for this problem? (medication, physical therapy, chiropractor treatments, etc.)

_____
_____

Does anything make the pain better or worse?

_____
_____

Please circle the appropriate number below showing how bad your pain was **INITIALLY** after the injury:

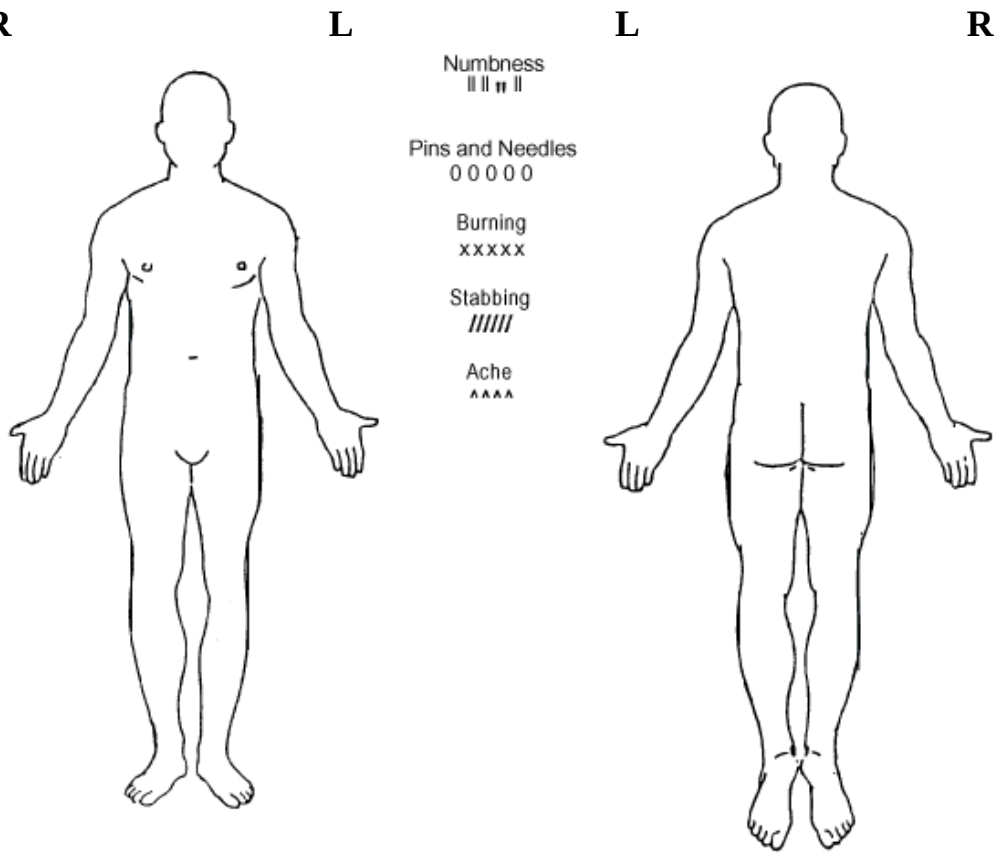
No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Please circle the appropriate number below showing how bad your pain is **NOW**:

No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Patient Name: _____

Pain Diagram (Please draw where your pain is)



Past Medical History:

□Diabetes	□Hypertension	□Heart Disease
□Heart Attack	□Renal/Kidney Disease	□Cancer
□GI/Stomach	□Recent Weight Loss	□Epilepsy
□Arthritis	□Gout	□Sexual Difficulties
□Hepatitis	□HIV	

Other:_____

Past Surgical History:

_____

_____

Current Medications and Dose:

_____

_____

Allergies to Medications:

_____

Family History: (arthritis, medical problems, or adverse reactions to anesthesia)

_____

_____

Patient Name: _____

Social History: (Do you use any of the below?)

Tobacco products or Nicotine Patch (Type and frequency)_____
Alcohol (how much/frequency)_____
Street Drugs_____

REVIEW OF SYMPTOMS (Circle all that apply)

1. CONSTITUTIONAL
Depression Anxiety

2. EYES
Blurred Vision Trouble Seeing

3. EARS, NOSE, MOUTH, THROAT
Sore Throat Trouble Hearing

4. Cardiovascular
Heart Racing Chest Pain

5. RESPIRATORY
Breathing Difficulty
Shortness of Breath

6. GASTROINTESTINAL
Diarrhea Constipation

7. GENITOURINARY
Blood in Urine Urinary Stones

8. INTEGUMENT
Skin rash Birth Marks

9. NEUROLOGIC
Seizures Headaches
Dizziness

10. PSYCHIATRIC
Schizophrenia Bipolar Illness

11. ENDOCRINE
Goiter Thyroid Disease

12. HEMATOLOGIC/LYMPHATIC
Anemia Bleeding Problems

13. Allergies
Hay Fever Iodine IV Contrast

Any other concerns or questions for the doctor:_____

_____

_____

_____

_____

Patient section stops here.