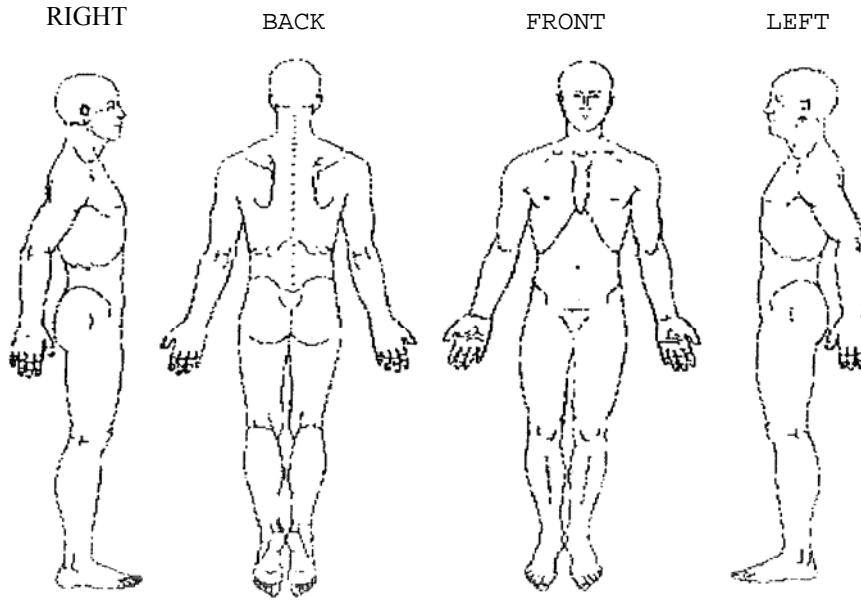


PAIN AND DISABILITY: (Section B)

This section pertains to **pain only**. You will have an opportunity to answer questions about numbness and tingling in **section C**.

- Does your neck or back problem cause pain? No (please **skip** to section C)
 Yes (Continue this section) Mark your **pain** on the fig below.

Please mark on the figure below to show where you feel **pain**.



Pain scale 0-10 (0= No pain, 10= pain severe enough to pass out)

What number would you give your pain today? _____
 What number would you give your pain on average? _____
 What number would you give your pain at its worse? _____

Please check all that describe your pain:

- Burning Sharp/Stabbing Tingling Aching Throbbing
 Shooting Pulling/Tearing Cramping Other: _____

Please check all of the appropriate responses in each category to complete the phrase “ My pain... “

- began suddenly began gradually interrupts my sleep
 is constant comes and goes

My pain is worse.....

- during the day at night in the AM in the afternoon

My pain is worse when.....

- Walking Running Standing Sitting Bending lifting driving
 applying heat applying ice exercising Frequently changing positions Lying
 sports (list) _____ Over head activity **Nothing makes my pain worse**

My pain is better while.....

- Walking Running Standing Sitting Bending lifting driving
- applying heat applying ice exercising Frequently changing positions Over head activity
- Lying on Back Lying on Side Lying on Stomach Recliner sports (list) _____
- Nothing makes my pain better**

Overall, which single word or phrase would you use to describe your pain the majority of the time?

- Trivial/Minimal Annoying Limiting Disabling Unbearable

Because of my pain, I am unable to.....

- Walk over _____miles Run over _____miles Sit longer than _____min/hours
- Stand longer than _____min/hrs Lift over _____lbs

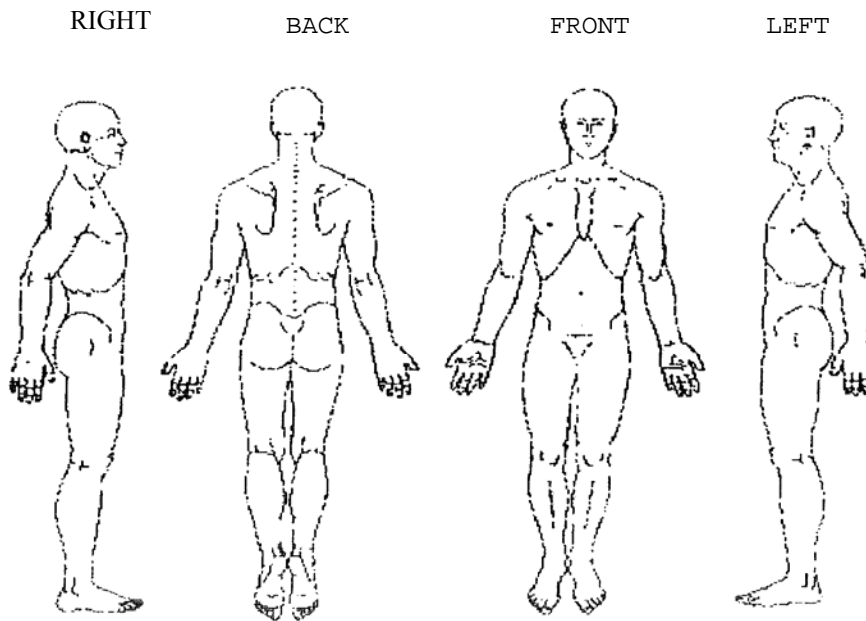
NUMBNESS/TINGLING (Section C)

This section pertains to numbness/tingling **only**. Questions about pain are in the previous section (**section B**).

Do you feel numbness or tingling?

- No (please **skip** to section D)
- Yes (continue this section)

Please mark on the figure below to show where you feel **numbness** (loss of feeling) or **tingling** (pins and needles).



My numbness and tingling is made worse while.....

- Walking Running Standing Sitting Bending lifting driving
- heat Ice exercising Frequently change of position
- sports (list) _____ **Nothing makes my pain worse**

Your treatment history (Please check all that apply)

	Complete relief	Improved	Unchanged	Worse
Physical Therapy				
Home Exercises				
Chiropractic				
Epidural Steroid Injection (performed in the Hospital)				
Facet Joint Injection (performed in the Hosp)				
Local or Trigger Point Injection (performed in the office)				
Massage				
Brace, Corset, or other support				
Accupuncture				
Other				
I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS				

Please list all medication you have tried **RELATED ONLY** for your spine, the dose, and the number of pills used per day for this problem.

(**examples** = naproxen, voltaren, ibuprofen, vicodin, percocet, oxycontin, darvocet, morphine, soma, flexeril, robaxin, baclofen, celebrex, vioxx, bextra. etc)

When last used? mm/yy	Medication	Dose	Number of pills per day	Did the medication help?
	Example: Motrin	800 mg	4	Very helpful

PRIOR SPINE SURGERY (Section G)

Have you ever had surgery on your spine? No (please skip to medical history)
 (This includes Fusions, decompressions, or any disc procedures) Yes (complete this section)

Date	Procedure	Rate the outcome of surgery Poor, good or excellent (See Legend below)

Legend: Poor = the surgery had no change or made me worse
 Good = the surgery improved my symptoms
 Excellent = Dramatically improved or resolved my symptoms

General Medical Section

(Complete all areas below)

MEDICAL HISTORY

Please check or circle any medical problem you currently have, or have experienced in the past.

<input type="checkbox"/>	Diabetes(Sugar)	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Hypertension (high blood pressure)
<input type="checkbox"/>	Stroke or Aneurysm	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Emphysema/COPD
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Blood Clotting Problems	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Kidney/Bladder problems	<input type="checkbox"/>	Valley Fever (coccidiomycosis)
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	Other Joint Pain	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Reflux Disease
<input type="checkbox"/>	Depression	<input type="checkbox"/> Psychiatric illness:			
Cancer (type):					
<input type="checkbox"/>	No medical problems		<input type="checkbox"/> Other:		

What medications do you take for problems UNRELATED to your spine?

Medication	Dose

Please list all non-spine related surgeries:

Procedure	Date (month/year)

Please list all the Doctors you have seen in the last 2 years:

Doctor	Issue or Problem

MEDICATION ALLERGIES

I do not know of any allergies or reactions to any medication

I am allergic to (Please circle and give reaction below:

Sulfa	Codeine	Penicillin (PCN)	Latex	Contrast Dye	Shellfish
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(Please use other side if necessary)

Medication	Reaction

FAMILY HISTORY

Please check next to any medical problem that runs in your family.

<input type="checkbox"/> Diabetes(Sugar)	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hypertension (high blood pressure)
<input type="checkbox"/> Stroke or Aneurysm	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney/Bladder problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Valley Fever (coccidiomycosis)	<input type="checkbox"/> Stomach Ulcers or Reflux disease (Peptic ulcer, hiatal hernia, etc)
<input type="checkbox"/> Osteoarthritis (Degenerative)	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Cancer (type): _____
<input type="checkbox"/> Depression		<input type="checkbox"/> Psychiatric illness: _____
<input type="checkbox"/> There are no medical problems in my family	<input type="checkbox"/> Other: _____	

SOCIAL HISTORY

What is your current occupation? _____
 How long? _____

Please check all that apply to your work or school status:

- I have missed no time from work or school because of my spine problem
- I am currently working full time
- I have missed a total of _____ days from work or school because of my spine problem
- I am working

<input type="checkbox"/> Part time	<input type="checkbox"/> Limited duty
------------------------------------	---------------------------------------
- I am unable to work at all because of my spinal problem
- I am unable to work at all because of another problem not related to my spine (diagnosis) _____
- The last date I worked was: _____
- I have been receiving worker's compensation since _____
- I have been on disability since _____

What is your marital status?

<input type="checkbox"/>	Single	<input type="checkbox"/>	Married	<input type="checkbox"/>	Separated	<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Widowed
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What is your living situation?

<input type="checkbox"/>	Homeless	<input type="checkbox"/>	with children	<input type="checkbox"/>	with spouse	<input type="checkbox"/>	with relatives	<input type="checkbox"/>	Alone
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List your recreations or sports with frequency and duration.

Please check all that apply to you:

- I never smoked cigarettes
- I quit smoking _____ years/months ago
- I smoke cigarettes at _____ packs per day
- I have smoked for _____ years
- I chew tobacco
- I never drink alcohol
- I drink alcohol

<input type="checkbox"/>	Very often	<input type="checkbox"/>	Daily	<input type="checkbox"/>	Weekly	<input type="checkbox"/>	Monthly	<input type="checkbox"/>	rarely
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- I am recovering from a drinking problem
- Recreational drug use
- I have not, nor do I plan to take legal action related to this injury.
- I am considering or have taken legal action as a result of this injury.
- Legal action related to this injury is closed or settled.

REVIEW OF SYSTEMS

Please check all problems below that apply to you.

<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Nausea and Vomiting	<input type="checkbox"/>	Fever
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Chills
<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Anxiety or Nervousness	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Bowel Incontinence (Uncontrolled defecation)
<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Unable to Urinate
<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>	Loss of Appetite

Thank you for completing the questionnaire. It will be incorporated into your initial evaluation.

The End