Spine Questionnaire

West Michigan Spine Center
A Division of Orthopaedic Associates of Muskegon

231 733-1326 | www.wmspinecenter.com

PATIENT INFORMATION

Name ______________________ Date ______________

Birth Date ______________ Marital Status ______________ Spouse ______________

Height ______________ Weight ______________ ☐ Right Handed ☐ Left Handed

Are you involved in a lawsuit or litigation? ☐ Yes ☐ No If yes, attorney's name: ______________

EMPLOYMENT INFORMATION

Employer ______________________

Current Job Title ______________________

Describe your job in detail: ______________________

____

How long have you been doing this job? ______________ How long have you been employed in the same company? ______________

Do you think you are able to work now? ☐ Yes (regular job) ☐ Yes (restricted job) ☐ No

Where did you work before? ______________ How long did you work there? ______________

What were your job responsibilities? ______________________

Highest school grade completed: __________ Can you read? __________ Can you write? __________

CHIEF COMPLAINT

What were you doing when the pain started?

☐ Lifting ☐ Twisting ☐ Bending ☐ Pulling ☐ Falling

☐ Hit in the back ☐ Car accident ☐ Sports ☐ Working ☐ No apparent injury

Other: ______________________

Describe what happened in detail:

____

____

What makes your pain better or worse?

Twisting	☐ better	☐ worse	☐ no change
Bending	☐ better	☐ worse	☐ no change
Sitting	☐ better	☐ worse	☐ no change
Standing	☐ better	☐ worse	☐ no change
Walking	☐ better	☐ worse	☐ no change
Lying down	☐ better	☐ worse	☐ no change
Coughing / sneezing	☐ better	☐ worse	☐ no change
Bowel movements	☐ better	☐ worse	☐ no change
Pain pills	☐ better	☐ worse	☐ no change
Muscle relaxants	☐ better	☐ worse	☐ no change
Aspirin	☐ better	☐ worse	☐ no change

Other ______________________

Why are you seeking treatment? What goal do you wish to achieve?

____

____

Do you have a strong support system (family or close friends who assist you)? ☐ Yes ☐ No

Do you have a spouse of children or other family members you are responsible for? ☐ Yes ☐ No

Who? ____

Are you able to fulfill all of your responsibilities? ☐ Yes ☐ No

Have there been any big changes in your life recently (death, divorce, etc.)? ☐ Yes ☐ No

If yes, describe: ____

What are your current activities? (include hobbies)

____

____

Is this a change from your previous level of activity? ☐ Yes ☐ No

If yes, in what way? ____

____

HISTORY

Do you have back/neck pain only? ☐ Yes ☐ No

Do you have arm/leg pain? ☐ Yes ☐ No

Do you have numbness? ☐ Yes ☐ No If yes, where: ______________________

Do you have tingling? ☐ Yes ☐ No If yes, where: ______________________

Did the pain start suddenly? ☐ Yes ☐ No If yes, date: ______________________

Is the pain constant? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Do you sleep on a waterbed? ☐ Yes ☐ No

Have you ever been treated for back/neck trouble before? ☐ Yes ☐ No If yes, by whom: ______________________

What was the treatment? ____

Who is your family doctor? ____

CURRENT MEDICATIONS Please list dose and frequency. (Ex: Aspirin – 325mg – 2 times daily)

____

____

____

____

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____

____

____

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Have you had any of these tests?

Test	Where	When
X-rays	Where: ____	When: ____
CT scan	Where: ____	When: ____
MRI	Where: ____	When: ____
EMG	Where: ____	When: ____
Myelogram	Where: ____	When: ____
Bone scan	Where: ____	When: ____
Discogram	Where: ____	When: ____
Other	Where: ____	When: ____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list and note type of reaction. (Ex: What happened when you took this drug?)

______

______

Do you smoke? ☐ Yes ☐ No If yes, how much? ____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much? ____

Do you have any of the following?

Diabetes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No	Breathing problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Stomach problems / Ulcers	☐ Yes	☐ No
Bowel problems	☐ Yes	☐ No			

If yes, what kind? ____

Bladder problems ☐ Yes ☐ No

If yes, what kind? ____

Sexual difficulty since your back/neck problems? ☐ Yes ☐ No

Weight loss/gain? ☐ Yes ☐ No If yes, how much? ____

History of chronic pain ☐ Yes ☐ No

Family history of chronic pain, back/neck problems, or arthritis? ☐ Yes ☐ No

Have you had any previous surgery? ☐ Yes ☐ No If yes, list procedure(s) and date(s):

______

______

______

______

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Please fill in the diagram showing where your pain is and what kind it is:

═══ = Numbness °°°°°°° = Pins and Needles /////// = Stabbing Pain

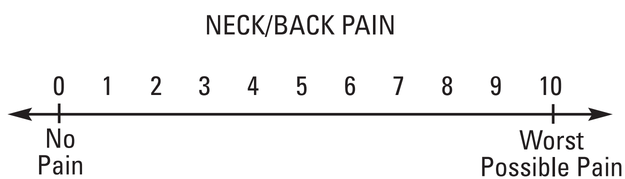
XXXXX = Burning VVVVV = Aching

RIGHT LEFT LEFT RIGHT

FRONT BACK

Please rate your pain using the two diagrams below: (circle number)

NECK/BACK PAIN



LEG/ARM PAIN