NEW SPINE PATIENT QUESTIONNAIRE

Patient Name _____ **Today's Date** _____

Age _____ **Date of Birth** _____ **Sex: M or F**

Primary Care Doctor _____

Referring Doctor _____

Please carefully complete the forms below before your upcoming appointment.

It will give us a better understanding of your problem and enable us to provide the best possible medical care.

Thank you for your cooperation.

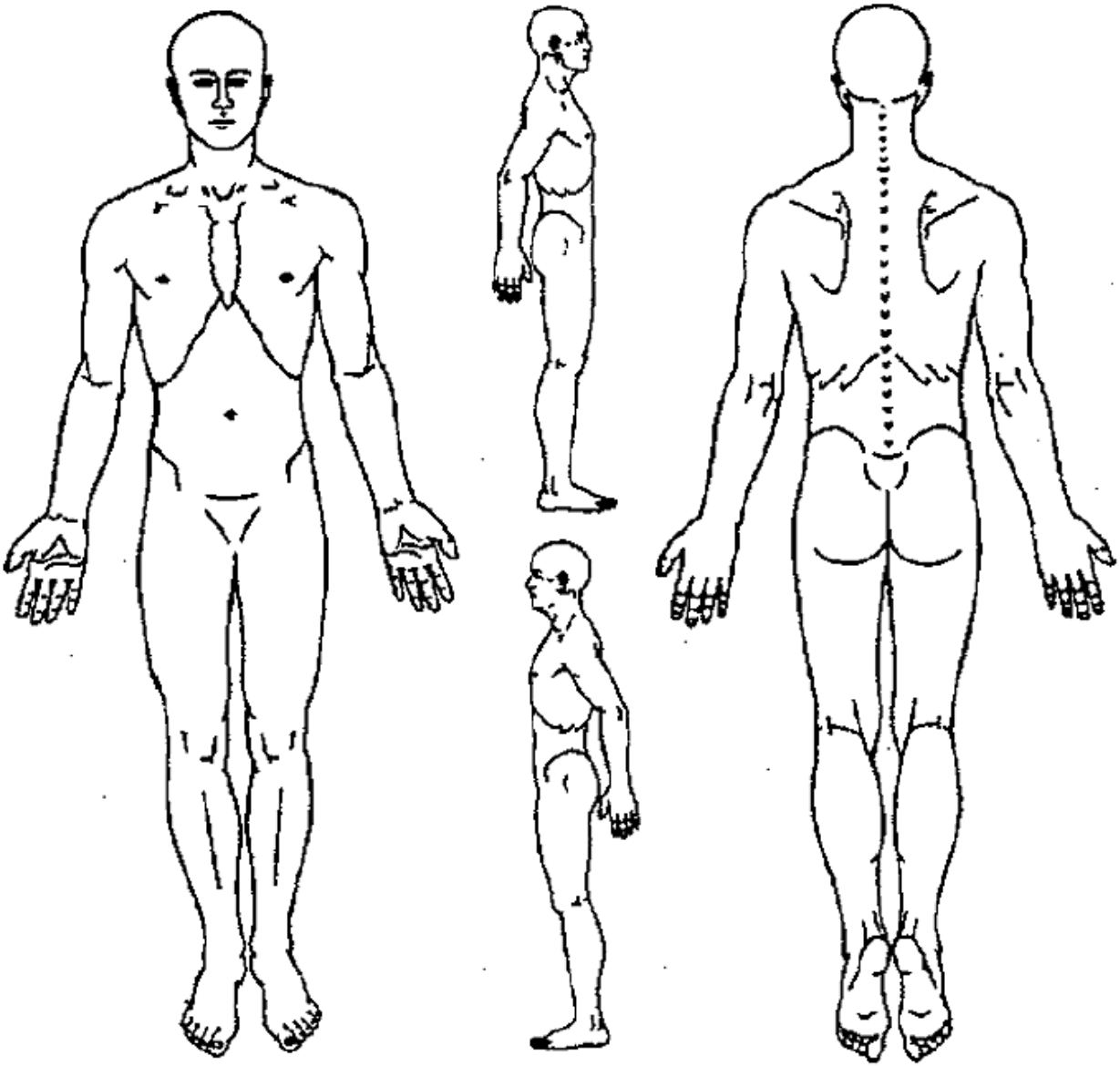
Benjamin Buterbaugh, DO

Orthopaedics East

PAIN DIAGRAM

Please mark the areas where you feel the following sensations.

	xxx		ooo		---		^^^		///
Ache	xxx	Numbness	ooo	Tingling	---	Burning	^^^	Stabbing	///
	xxx		ooo		---		^^^		///



HISTORY OF PRESENT ILLNESS

How and when did your back or neck problem begin?

- ☐ Injury (Date of Injury: _____)
  - How did the injury happen: _____
- ☐ On-the-job
- ☐ I don't know how it began
- ☐ I've had it for about _____ weeks / months / years (circle one)
- ☐ It comes and goes OR ☐ it is constant

Please circle the number that describes your pain today for each body location

Low back pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Leg pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Upper back pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Neck pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

Arm pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain

For patients with NECK or ARM pain, numbness or weakness (skip to next page if you have none):

Raising the arm: ☐ improves the pain ☐ worsens the pain ☐ no change

Moving the neck: ☐ improves the pain ☐ worsens the pain ☐ no change

There is: ☐ weakness ☐ NO weakness in the arms or hands

There is: ☐ numbness or tingling ☐ NO numbness or tingling in the arms or hands

Have you noticed clumsiness, difficulty buttoning buttons or picking up small objects like coins? ☐ yes ☐ no

Have you noticed balance problems or do you trip easily? ☐ yes ☐ no

For patients with BACK or LEG pain, numbness or weakness (skip if you have none):

Do you have pain that goes below your knees? ☐ yes ☐ no

There is weakness of my:

LEFT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no weakness

RIGHT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no weakness

There is numbness of my:

LEFT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no numbness

RIGHT: ☐ thigh ☐ calf ☐ ankle ☐ foot ☐ toe ☐ no numbness

The worst position for your pain is: ☐ sitting ☐ standing ☐ walking

How many minutes can you STAND in one place without pain?

☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

How many blocks can you WALK without having to stop and rest due to pain?

☐ less than 1 ☐ 1-3 ☐ 1 mile ☐ 2 miles or more

Lying down: ☐ eases my pain ☐ makes it worse ☐ no change

Bending forward: ☐ eases my pain ☐ makes it worse ☐ no change

ALL PATIENTS please answer the following:

Does coughing or sneezing worsen your pain? ☐ yes ☐ no

There is: ☐ NO loss of bowel or bladder control ☐ Loss of control since _____

Prior to my neck/back problem starting, I was:

- ☐ working full-time (Occupation:_____)
- ☐ working part-time (Occupation:_____)
- ☐ disabled, not working
- ☐ not working by choice (retired, student, etc)

I have:

- ☐ not missed any work because of this problem
- ☐ missed work (how much? _____)
- ☐ been out of work since _____

Because of this back/neck problem, do you have or plan to have:

☐ lawsuit ☐ worker's compensation claim ☐ unsure ☐ none

Previous Spine Testing:			If Yes, date of most recent test and location:
X-Rays	No	Yes	_____
MRI	No	Yes	_____
Nerve Test (EMG/NCV)	No	Yes	_____

Other testing/imaging: _____

Previous Spine Treatments:

Treatments so far for my BACK or NECK problem include:

- ☐ Physical therapy (How many visits? _____ Last visit? _____)
- ☐ Chiropractic care (How many visits? _____ Last visit? _____)
- ☐ Anti-inflammatory medications (e.g. Motrin, Advil, Aleve, ibuprofen, naproxen)
- ☐ Narcotic medication (e.g. Tylenol #3, hydrocodone, oxycodone)
- ☐ Other medications: _____
- ☐ Chiropractic ☐ Massage ☐ TENS unit ☐ Brace ☐ Psychological consultation
- ☐ Other Treatment: _____

Previous Injections:

- ☐ Epidural Steroid Injections
  - How many: _____
  - How long did relief last: _____
  - What provider did your injection? _____
- ☐ Sacroiliac Joint Injections
  - How many: _____
  - How long did relief last: _____
  - What provider did your injection? _____
- ☐ Branch Blocks
  - How many: _____
  - How long did relief last: _____
  - What provider did your injection? _____
- ☐ Radiofrequency Ablations (RFA)
  - How many: _____
  - How long did relief last: _____
  - What provider did your injection? _____
- ☐ Other injections: _____

Previous doctors you have seen for your back/neck problem:

Doctor	Specialty	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had surgery on your SPINE? ☐ Yes ☐ No If yes, complete the following:

Type of surgery _____ Type of surgery_____

When _____ When _____

Surgeon _____ Surgeon _____

Did it help your pain? ☐ Yes ☐ No Did it help your pain? ☐ Yes ☐ No

General Medical History

- ☐ Are you a diabetic Yes No
  - Is your blood sugar currently well controlled Yes No
  - Do you take insulin? Yes No
  - Please list your diabetes medications: _____
- ☐ If you are female, are you pregnant or possibly pregnant? Yes No
- ☐ Are you currently taking any blood thinners (Aspirin, Eliquis, Warfarin, Plavix, Xarelto, Pradaxa, Effient). Please list below:

  _____
- ☐ Please list your allergies below:

  _____

END OF QUESTIONNAIRE