

Dear Patient,

Welcome to the Spine Center at Greater Metropolitan Orthopaedic Institute. In order to provide you with comprehensive spine care, we ask that you take a few minutes to complete the questionnaire below. If you need help completing this form, please ask one of our office staff to assist you.

Date _____

Patient Name _____ Age _____

Occupation _____ Work Status _____

Referring Doctor _____

Height _____ Weight _____

Have you ever smoked cigarettes, cigars, chewed tobacco or used electronic cigarettes? No Yes

If yes, current quantity _____ *Date quit* _____

What is the main reason for your visit today?

Back Pain Leg Pain Neck Pain Arm Pain

How did your current problem begin?

Lifting Twisting Falling Bending Pulling ----- suddenly gradually

Did your current spine problem result from any of the following?

Car Accident Work Injury Sports Injury Other

How long has this been a problem?

Less than 2 months 2-6 months 6-12 months Greater than 1 year

Have you been treated by any other medical provider for this condition?

If yes, please list name of provider. _____

Have you had a previous spine surgery? Type and date: _____

Have you had any diagnostic tests for this problem?

None X-Ray MRI CT EMG Bone Scan

What treatments have you had for this problem?

None Physical Therapy Epidural Injections Chiropractic Care Acupuncture

Are you currently involved or considering involvement in any type of litigation?

Lawsuit Workmen's Comp Disability Claim Social Security Claim Other

What makes your pain worse?

During Exercise After Exercise Prolonged Sitting Prolonged Standing Walking
Bending Forward Bending Backward Pushing/Pulling Squatting Sleeping/night Other: _____

What reduces your pain?

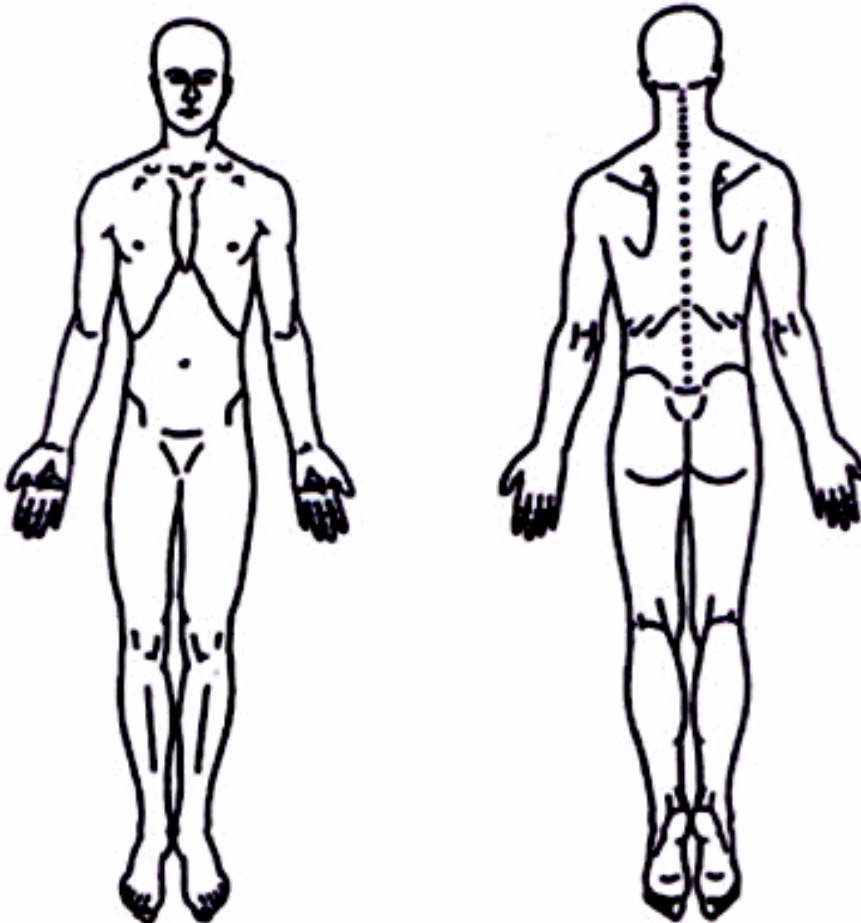
Nothing Lying down Sitting Standing Walking Shifting/Changing positions

What pain medications are you currently taking to reduce the pain? _____

Pain Diagram

Where is your pain located? Please draw on the body diagrams below to show where you feel the sensations listed in the table. Use the symbols in each category to help indicate the type of pain you are having. Please feel free to provide further detail regarding your pain.

Ache	Numbness	Burning	Stabbing	Pins and needles
AAA	OOO	XXX	///	---



On a scale from 0-10, how would you rate your pain at this moment? _____

On a scale from 0-10, how would you rate your pain on your worst day? _____

On a scale from 0-10, how would you rate your pain on your best day? _____