

Spine/Musculoskeletal Questionnaire

Please complete all pages of this form. Your careful answers will help us to understand your presenting problem and design the best treatment program for you.

Name: _____
Last
First
M.I.

Referring Physician _____ Primary Care Physician _____

Date of Birth: _____

Main problem(s) for which you are seeking treatment: _____

Function (check one):

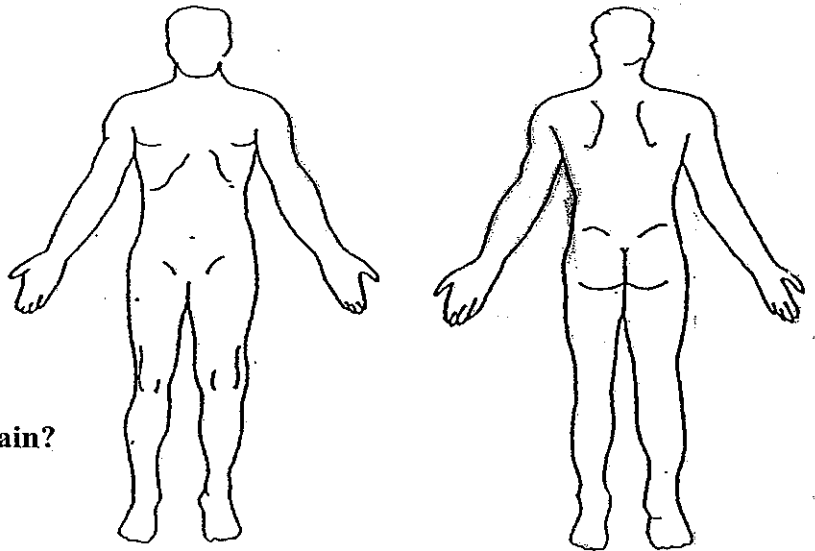
- I am able to do a little less than before my problem started
- I am able to do a lot less than before my problem started
- My activity level has not changed

Activities I am unable to do because of my pain: _____

Pain location:

Front

Back



Which of the following best describes your pain?

- Neck more than arm
- Arm more than neck
- Back more than leg
- Leg more than back

How would you describe the pain (choose all that apply)?

- burning
- sharp
- electric-like
- pins/needles
- shooting
- stabbing
- numb
- tearing
- penetrating
- aching
- gnawing
- dull
- throbbing
- miserable
- other _____

How do the following affect your pain?

	Better	Worse	No change	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing/sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you walk with a?	<input type="checkbox"/> cane		<input type="checkbox"/> walker	<input type="checkbox"/> crutches
			<input type="checkbox"/> none	

Past medications taken for this problem:

Inflammation

- Motrin (Ibuprofen)
- Aleve (Naproxen)
- Aspirin
- Celebrex (Celecoxib)
- Voltaren or Arthrotec
- Steroids (Cortisone, Prednisone)
- Other: _____

Opioids

- Darvocet (Propoxyphene)
- Percocet (Oxycodone)
- Methadone
- Lortab, Vicodin or Lorcet (Hydrocodone)
- Duragesic (Fentanyl)
- Other: _____

Spasms

- Flexeril (Cyclobenzaprine)
- Soma (Carisoprodol)
- Baclofen (Lioresal)
- Other: _____

Others:

- Neurontin (Gabapentin)
- Lyrica
- Ambien (Zolpidem)
- Topamax (Topiramate)
- Ultram (Tramadol)

Current Medications:

Name	Dose	How Often

Name	Dose	How Often

Allergies (please list all medication and type of reaction---what happened?)

Please check all treatments tried and then check the appropriate column:

Treatments	No relief	Some relief	Excellent relief
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Injections (Epidural, facets, Etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TEN'S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any back surgeries that you have had.

Date/Type/Surgeon: _____ Pain Relief? _____

Were you able to do more (improved function)? _____

Have you had any of the following health problems (please check all that apply)?

- High blood pressure
- Diabetes or high blood sugar
- Kidney disease
- Heart disease
- Sleep apnea
- Liver disease
- Asthma or wheezing
- Seizure or epilepsy
- Bleeding problems
- Cancer; please specify: _____
- Other; please specify: _____

Please list the diagnostic studies that you have had for this problem

Date	Result	Date	Result
<input type="checkbox"/>	MRI	<input type="checkbox"/>	EMG/NCS
<input type="checkbox"/>	CT or myelogram	<input type="checkbox"/>	Bone Scan
<input type="checkbox"/>	X-Rays	<input type="checkbox"/>	Discogram:

Please check all items you feel are applicable to you:

Constitutional

- recent infections
- fever/nightsweats
- fatigue
- weakness
- weight loss
- poor sleep

Eyes

- eye pain
- loss of vision
- blurred or double vision

Ears, Nose, Mouth, Throat

- ringing in the ears
- difficulty hearing
- sore throat
- sinusitis
- difficulty swallowing
- hoarse voice
- dry mouth

Cardiovascular

- chest pain
- shortness of breath
- heart racing or fluttering
- difficulty breathing at night
- leg or feet swelling

Musculoskeletal

- joint or muscle pain
- arm or leg weakness
- arm or leg numbness
- joint swelling

Respiratory

- cough
- pneumonia or bronchitis
- coughing up blood
- wheezing
- asthma

Gastrointestinal

- bowel accidents
- decreased appetite
- nausea/vomiting
- diarrhea
- constipation
- abdominal pain
- ulcers
- blood in stool
- indigestion

Genitourinary

- bladder accidents
- pain or burning with urination
- difficulty urinating
- blood in urine
- prostate problems
- difficulty with erections
- "private area" pain

Neurologic

- headache
- dizziness
- fainting
- loss of consciousness
- history of head injury

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Endocrine

- thyroid problems
- increased thirst
- excessive sweating

Hematologic/Lymphatic

- low blood count or anemia
- "easy" or "free" bleeding

Allergic/Immunologic

- latex allergy
- shellfish or iodine allergy

Psychiatric

- depression
- thoughts of killing yourself

Skin/Breasts

- rash or hives
- easy bruising
- breast lump
- breast pain

Have you experienced significant stress this past year? Please explain:

What is your occupation? _____ Hours per week? _____

Do you or did you ever smoke cigarettes? yes no Number of years/packs per day? _____

Do you consume alcoholic beverages (include number and how often)? _____

Family History: low back pain heart cancer blood pressure
 other: _____ arthritis

Please do not write below this area

Physician has reviewed the form and acknowledges the findings:

Signature _____