

Spine 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.

If you have completed a similar form for Dr. Prybis in our office within the past year, you do not need to complete this form.

Name _____
Last First M.I.

Today's date: _____

Referring Physician _____

Address _____

Primary Care Physician _____

Address _____

Other Physician(s) _____

Address _____

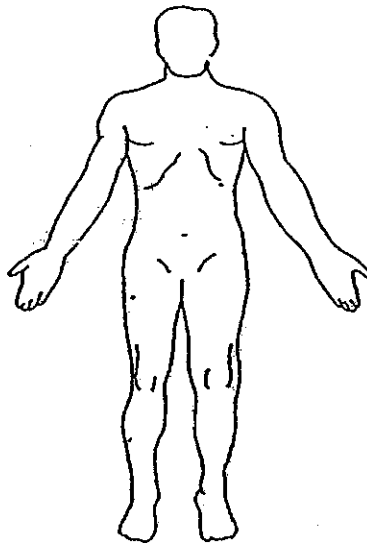
Main problem(s) for which you are seeking treatment: _____

Function (check one):

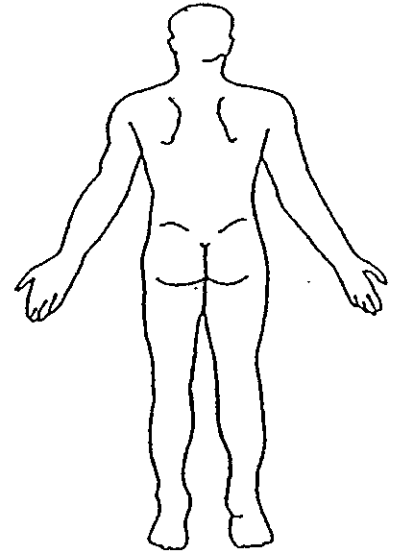
- I am able to do a little less than before my problem started.
- I am able to do a lot less than before my problem started.
- My activity level has not changed.

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 as many as 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?

	<u>Better</u>	<u>Worse</u>	<u>No Change</u>
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"/>

Please check the approximate amount of time you can perform the following activities at one time:

	15 minutes	30 minutes	1 hour	2 hours+
Sit				
Stand				
Walk				

Past medications taken for this problem:

Inflammation

- Motrin, Advil (Ibuprofen)
- Aleve (Naproxen)
- Aspirin
- Celebrex or Vioxx
- "Steroids" (Cortizone, Prednizone)
- Other: _____

Others

- Neurontin (Gabapentin)
- Ultram (Tramadol)
- Ambien (Zolpiden)
- Topamax (Topiramate)
- Other: _____

Spasms

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

Opioids

- Darvocet (Propoxyphene)
- Percocet (Oxycodone)
- Methadone
- Lortab (Hydrocodone)
- Duragesic
- Other: _____

Anxiety/Nerves

- Ativan (Lorazepam)
- Klonopin
- Xanax (Alprazolam)
- Other: _____

Depression

- Elavil (Amitriptyline)
- Trazodone (Desyrel)
- Prozac (Fluoxetine)
- Effexor (Venlafaxine)
- Other: _____

Current medications:

Name

Dose

How often

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

Please check all treatments and then check the appropriate column

Treatment	No Relief	Some Relief	Excellent Relief
<input type="checkbox"/> Physical Therapy	_____	_____	_____
<input type="checkbox"/> Occupational therapy	_____	_____	_____
<input type="checkbox"/> Surgery	_____	_____	_____
<input type="checkbox"/> Heat	_____	_____	_____
<input type="checkbox"/> Ice	_____	_____	_____
<input type="checkbox"/> Injections (epidural, facet, etc.)	_____	_____	_____
<input type="checkbox"/> TEN'S	_____	_____	_____
<input type="checkbox"/> Acupuncture	_____	_____	_____
<input type="checkbox"/> Chiropractic	_____	_____	_____

Please list all surgeries that you have had (indicate the approximate date and type of operation(s):

Back surgery

Type: _____

Were you able to do more? _____

Other surgeries of any type: _____

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 all of the diagnostic studies that you have had for this problem (indicate date and results):

MRI

CT

X-Rays

Discogram

Myelogram

EMG/NCS

Bone Scan

Other:

Please check all items you feel are applicable to you:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> recent infections | <input type="checkbox"/> fever or chills | <input type="checkbox"/> weight loss | <input type="checkbox"/> arm numbness |
| <input type="checkbox"/> leg numbness | <input type="checkbox"/> genital numbness | <input type="checkbox"/> chest pain | <input type="checkbox"/> muscle weakness |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> appetite changes | <input type="checkbox"/> bowel accidents | <input type="checkbox"/> loss of control of bowels |
| <input type="checkbox"/> poor sleep | <input type="checkbox"/> swollen glands | <input type="checkbox"/> headaches | <input type="checkbox"/> eye pain |
| <input type="checkbox"/> bladder accidents | <input type="checkbox"/> loss of control of bladder | <input type="checkbox"/> double vision | <input type="checkbox"/> loss of vision |
| <input type="checkbox"/> sinusitis | <input type="checkbox"/> severe nighttime pain | <input type="checkbox"/> sore throats | <input type="checkbox"/> hoarse voice |
| <input type="checkbox"/> low blood count | <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> difficulty hearing | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> leg swelling | <input type="checkbox"/> pneumonia | <input type="checkbox"/> bronchitis | <input type="checkbox"/> asthma |
| <input type="checkbox"/> cough | <input type="checkbox"/> coughing blood | <input type="checkbox"/> sputum | <input type="checkbox"/> heart "racing"/fluttering |
| <input type="checkbox"/> ulcer | <input type="checkbox"/> bloating | <input type="checkbox"/> diarrhea | <input type="checkbox"/> nausea |
| <input type="checkbox"/> constipation | <input type="checkbox"/> sticky/tarry stool | <input type="checkbox"/> difficult urination | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> arthritis | <input type="checkbox"/> dry eyes | <input type="checkbox"/> red joints |
| <input type="checkbox"/> painful urination | <input type="checkbox"/> dry mouth | <input type="checkbox"/> blood in urine | <input type="checkbox"/> frequent bladder infection |
| <input type="checkbox"/> gout | <input type="checkbox"/> swollen joints | <input type="checkbox"/> muscle aches | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> jitteriness | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> excess sweating | <input type="checkbox"/> menopause |
| <input type="checkbox"/> painful periods | <input type="checkbox"/> genital pains | <input type="checkbox"/> painful intercourse | <input type="checkbox"/> difficulty with erections |
| <input type="checkbox"/> loss of sexual desire | <input type="checkbox"/> prostate enlargement | <input type="checkbox"/> rash | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> blood in stool | <input type="checkbox"/> indigestion | | |

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

What is your occupation? _____

Are you currently working? yes no If yes, how many hours per week? _____

Are you single married widowed separated divorced?

If you have biological children, what are there ages? _____

Do you or did you ever smoke cigarettes? yes no

How many years have you or did you smoke, and how many packs per day? _____

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

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

Please do not write below this area

Physician has reviewed the form and acknowledges the findings

X _____
Signature