

# Scoliosis & Spine Questionnaire

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
File Number \_\_\_\_\_  
Date: \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

**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.**

Referring Physician \_\_\_\_\_ Address \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_  
Other Physician(s) \_\_\_\_\_ Address \_\_\_\_\_

Are you  Right  Left Handed? Your Age \_\_\_\_\_ Sex:  Male  Female

What is/are the main problem(s) for which you are seeking treatment? \_\_\_\_\_

When did your current problem start? \_\_\_\_\_ (month/day/year)

Have you ever had similar problems before?  Yes  No \_\_\_\_\_

Did your symptoms start  suddenly  gradually?

### Please indicate how your present symptoms began:

- During an athletic activity
- While seated
- While bending
- As a result of an auto accident
- While lifting
- While working
- Unknown

### Please indicate the most appropriate statement:

- My symptoms have remained the same since the time of the injury.
- My symptoms are more severe since the time of the injury.
- My symptoms are less severe since the time of the injury.

### Have the symptoms of your pain changed?

- They are unchanged.
- increased aggravation in the arm or legs
- increased aggravation in both arms or legs
- increased aggravation in the back or neck
- increased aggravation in both arms/legs and back/neck

### Which of the following best describes your pain ratio?

- 100% back/neck pain
- 75% back/neck pain & 25% leg/arm pain
- 50% back/neck pain & 50% leg/arm pain
- 25% back/neck pain & 75% leg/arm pain
- 100% leg/arm pain

### Please indicate below where your pain/symptom(s) was/were initially located:

- neck  Mid back
- low back and legs  neck & arms
- low back  unknown

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You have already provided us with information about your present pain. Please give us the approximate dates of any other episodes of back/neck pain:

Episode A      /      /      \_\_\_\_\_

Episode B      /      /      \_\_\_\_\_

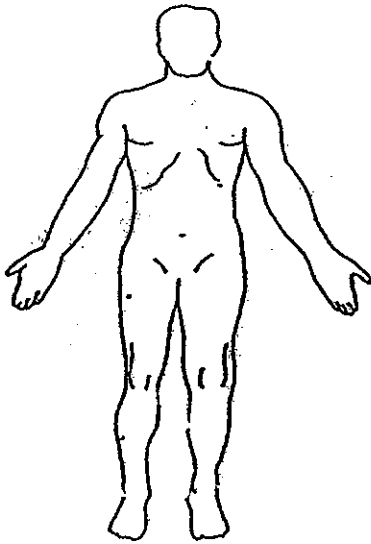
Is your pain (please check one):

- |  |  |
|--|--|
| <input type="checkbox"/> constant?                               | <input type="checkbox"/> intermittent and occurring daily? |
| <input type="checkbox"/> intermittent and occurring on most days | <input type="checkbox"/> infrequent?                       |

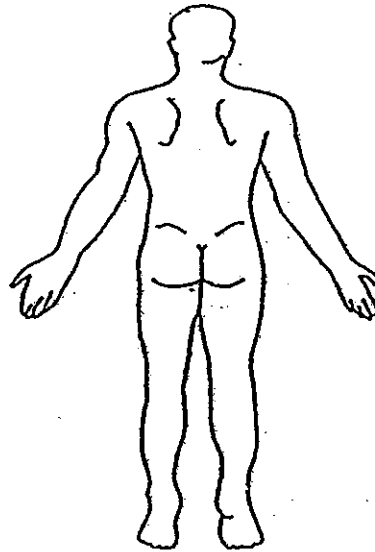
How would you describe the pain (choose as many adjectives as applicable)?

- |                                   |                                |  |                                       |                                      |
|-----------------------------------|--------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> burning  | <input type="checkbox"/> sharp | <input type="checkbox"/> electric-like | <input type="checkbox"/> pins/needles | <input type="checkbox"/> shooting    |
| <input type="checkbox"/> stabbing | <input type="checkbox"/> numb  | <input type="checkbox"/> tearing       | <input type="checkbox"/> penetrating  | <input type="checkbox"/> aching      |
| <input type="checkbox"/> gnawing  | <input type="checkbox"/> dull  | <input type="checkbox"/> throbbing     | <input type="checkbox"/> miserable    | <input type="checkbox"/> other _____ |

**PAIN LOCATION:** (Please mark the location(s) of your pain on the diagrams below)



*Front*



*Back*

**PAIN SEVERITY**

Circle your average level of pain over the last month:

(no pain) 0    1    2    3    4    5    6    7    8    9    10 (severe)

Circle your current pain:

(no pain) 0    1    2    3    4    5    6    7    8    9    10 (severe)

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**RELIEVING AND AGGRAVATING FACTORS:** How do the following affect your pain? Check one for each item.

	Decrease	No Change	Increase
Standing	_____	_____	_____
Sitting	_____	_____	_____
Walking	_____	_____	_____
Rising and sitting	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Lying on your back	_____	_____	_____
Lying on your side	_____	_____	_____
Lying on your stomach	_____	_____	_____
Coughing/Sneezing	_____	_____	_____
Urination	_____	_____	_____
Bowel movements	_____	_____	_____
Medications	_____	_____	_____
Relaxation	_____	_____	_____

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

	Unable	15 minutes	30 minutes	45 minutes	1 hour	Indefinitely
Sit						
Stand						
Walk						

**PAST MEDICATIONS:** Use the list below to indicate the prescription medications that you have tried in the past for your present problem. Please tell us the dosage and number of pills you took of this medication per day.

**Opioids**

- Tylenol with codeine
- Darvocet (Propoxyphene)
- Percocet
- Vicodin
- Dilaudid (Hydromorphone)
- Oxycontin
- MS Contin
- Methadone
- Duragesic (Fentanyl) patch
- Levorphanol
- Demorol (Meperidine)
- Kadian

**Anti-inflammatories (NSAIDS)**

- Ibuprofen (Motrin, Advil)
- Naprosyn (Naproxen)
- Aleve (Naproxen)
- Aspirin
- Lodine (Etodolac)
- Relafen (Nabumetone)
- Feldene (Piroxicam)
- Indomethacin (Indocin)
- Toradol (Ketorolac)
- Vioxx (Rofecoxib)
- Celebrex (Celecoxib)
- Steroids (Prednisone, Cortisone, etc.)

**Antidepressants**

- Elavil (Amitriptyline)
- Pamelor (Nortriptyline)
- Norpramin (Desipramine)
- Sinequan (Doxepin)
- Trazodone (Desyrel)
- Zoloft (Sertraline)
- Prozac (Fluoxetine)
- Paxil (Paroxetine)
- Wellbutrin (Bupropion)
- Effexor (Venlafaxine)
- Serzone (Nefazodone)

**Antispasmodics**

- Flexeril (Cyclobenzaprine)
- Soma (Carisoprodol)
- Baclofen (Lioresal)
- Zanaflex (Tizanidine)
- Norflex (Orphenadrine)
- Robaxin (Methocarbamol)

**Anti-anxiety**

- Ativan (Lorezapam)
- Klonopin (Clonazepam)
- Valium (Diazepam)
- Xanax (Alprazolam)
- Halcion (Triazolam)
- Buspar (Buspirone)
- Serax (Oxazepam)

**Others**

- Neruontin (Gabapentin)
- Ultram (Tramadol)
- Ambiem (Zolpidem)
- Topomax (Topiramate)
- Dilantin (Phenytonin)
- Tegretol (Carbamazepine)
- Lamictal (Lamotrigine)

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**CURRENT MEDICATIONS** (Please fill out the dosages and how often taken):

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES** (Please indicate the names of any medications that you are allergic to (and what happened to you):

\_\_\_\_\_

Please check all of the treatments that you have tried for your pain and then complete the appropriate column:

Treatment	date (approx)	No Relief	Moderate 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"/> Traction	_____	_____	_____	_____
<input type="checkbox"/> Injections (epidural, facet, etc.)	_____	_____	_____	_____
<input type="checkbox"/> TENS	_____	_____	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____	_____	_____
<input type="checkbox"/> Spine extension	_____	_____	_____	_____
<input type="checkbox"/> Spine flexion	_____	_____	_____	_____
<input type="checkbox"/> Brace or collar	_____	_____	_____	_____
<input type="checkbox"/> Massage	_____	_____	_____	_____
<input type="checkbox"/> Meditation	_____	_____	_____	_____
<input type="checkbox"/> Hypnosis (self)	_____	_____	_____	_____
<input type="checkbox"/> Psychotherapy	_____	_____	_____	_____
<input type="checkbox"/> Biofeedback	_____	_____	_____	_____
<input type="checkbox"/> Acupuncture	_____	_____	_____	_____
<input type="checkbox"/> Chiropractic	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____

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

Laminectomies/disectomies:
Fusions:
Chymopapain injection (chemonucleolysis):
Other surgeries:

**Did you improve from your surgical procedure(s)?**

- First procedure             yes    no  
Second procedure         yes    no  
Third procedure           yes    no

**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

**Please check all items you feel are applicable to you:**

- recent infections     fever or chills         weight loss         arm numbness         leg numbness
- genital numbness     muscle weakness     fatigue             appetite changes     bowel accidents/incontinence
- poor sleep             swollen glands       headaches         eye pain             bladder accidents/incontinence
- double vision         loss of vision         sinusitis           sore throats         severe nighttime pain
- hoarse voice          anemia                 cold hands/feet     difficulty hearing     chest pain
- ringing ears          leg swelling          pneumonia          bronchitis           asthma
- cough                  cough blood          sputum              murmur               palpitations
- shortness of breath

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Please check all items you feel are applicable to you:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> ulcer               | <input type="checkbox"/> bloating       | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> nausea                      |
| <input type="checkbox"/> constipation        | <input type="checkbox"/> black 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 infections |
| <input type="checkbox"/> limited motion      | <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"/> cold intolerance    | <input type="checkbox"/> menopause      | <input type="checkbox"/> painful periods     | <input type="checkbox"/> vulvar pain                 |
| <input type="checkbox"/> painful intercourse | <input type="checkbox"/> impotence      | <input type="checkbox"/> eczema              | <input type="checkbox"/> loss of sexual desire       |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> rash           | <input type="checkbox"/> psoriasis           | <input type="checkbox"/> hypersensitivity            |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> blood in stool | <input type="checkbox"/> indigestion         | <input type="checkbox"/> feeling depressed           |
| <input type="checkbox"/> anxiety/nervousness |   |  |  |

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

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> high blood pressure            | <input type="checkbox"/> diabetes or high blood sugar | <input type="checkbox"/> kidney disease    |
| <input type="checkbox"/> heart disease                  | <input type="checkbox"/> sleep apnea                  | <input type="checkbox"/> liver disease     |
| <input type="checkbox"/> asthma or wheezing             | <input type="checkbox"/> seizure or epilepsy          | <input type="checkbox"/> bleeding problems |
| <input type="checkbox"/> cancer (please specify): _____ |   |  |
| <input type="checkbox"/> other (please specify): _____  |   |  |

Do you have any pending health related litigation?  yes  no \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you currently working? \_\_\_\_\_

Is your job  sedentary  light  medium  heavy?

If you are currently unemployed, indicate how long you have been out of work: \_\_\_\_\_

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? \_\_\_\_\_

Is there a history of low back pain, arthritis, headaches, or other major chronic illness that runs in your family?

\_\_\_\_\_  
\_\_\_\_\_