



Carrollton Orthopaedic Clinic, P.C.

Scoliosis and Spine Questionnaire

Name: _____
Date of Birth: _____
Primary Doctor: _____
Height: _____ Weight: _____

Date: _____ Chart #: _____
Age: _____ Sex: [] Male [] Female
Who referred you? _____
BP: _____ P: _____

Spine - History of Present Illness/Injury

Symptoms (check all that apply):
[] Back Pain [] Upper [] Lower [] Neck Pain
[] Arm Pain [] Leg Pain

1. The pain has been present for:
[] days [] weeks [] months [] years
2. Circle pain level TODAY: 0=none 10=worst
[-----]
0 1 2 3 4 5 6 7 8 9 10
3. Level of pain on worst day: (0-10, 10=worst) _____

4. Is the pain? [] constant or [] comes and goes

5. Is the Pain? [] Sharp [] Dull [] Stabbing
[] Aching [] Burning [] Stiffness [] Other _____

6. Does the pain go down the arms or legs? [] yes [] no
If Yes: Arms: [] Right [] Left [] Both
Legs: [] Right [] Left [] Both

7. Do you have weakness: [] yes [] no
If Yes: Arms: [] Right [] Left [] Both
Legs: [] Right [] Left [] Both

8. Do you have numbness? [] yes [] no
If Yes: Arms: [] Right [] Left [] Both
Legs: [] Right [] Left [] Both

9. Is the pain worse when (check all that apply)?
[] sitting [] standing [] walking [] bending [] lifting
[] twisting [] lying down [] morning [] night [] other

10. The pain is better when (check all that apply):
[] sitting [] standing [] walking [] lying down
[] morning [] night [] other _____

11. Does the pain wake you up at night? [] yes [] no

12. Do you have trouble standing for a long time?
[] yes [] no If yes: _____ minutes

13. Do you have trouble walking for a long time:
[] yes [] no If yes: _____ minutes

14. Any difficulty with bowel or bladder? [] yes [] no
Describe: _____

15. Do you drop things with your arms/hands?
[] yes [] no

16. Are you clumsy with your hands? [] yes [] no

17. Do you have trouble with balance?
[] yes [] no

Treatment History: for spine condition

Medications: [] yes [] no If yes:
Anti inflammatory: [] yes [] no
Muscle relaxants: [] yes [] no
Other: _____

Have you had Physical Therapy? [] yes [] no
When? _____
Chiropractic? [] yes [] no When? _____
Home Exercises? [] yes [] no _____

Have you had an injection for spinal pain? [] yes [] no
Epidural Steroid Injection? [] yes [] no When? _____
Nerve Block? [] yes [] no When? _____
Facet Block? [] yes [] no When? _____

Have you had Spine Surgery? [] yes [] no
If yes, what type? _____
Names of Doctors that have treated you before for this
problem: _____

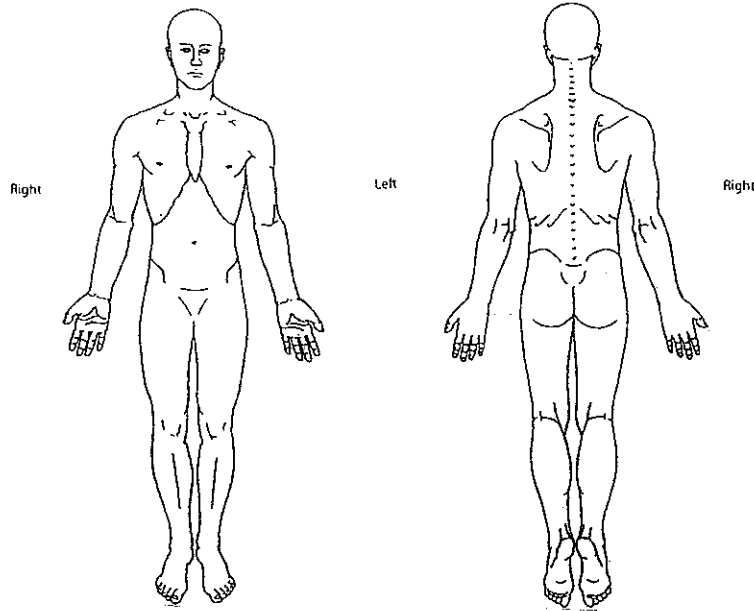
Tests you have had (check all that apply):
[] X-ray [] CT Scan [] Bone Density [] Myelogram
[] EMG/NCS [] MRI [] Bone Scan [] Discogram

Injury: Did you have an injury to cause pain?
[] yes [] no
Work Related? [] yes [] no Date _____
Auto Accident? [] yes [] no Date _____
Other type of injury? _____
Date of Injury? _____
Litigation Pending? [] yes [] no

Pain Drawing

Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

Key: Stabbing /// Burning XXX Pins & Needles 000 Numbness === Aching +++



Health History

Current Medications:

Not currently taking medication

Include herbal and over-the-counter drugs. List all with dose and condition treating. Use additional sheet if needed.

1 _____
2 _____
3 _____
4 _____

5 _____
6 _____
7 _____
8 _____

Medication Allergies:

No medication allergies

Have you ever had an allergic reaction to any of the following?

Ancef (cefazolin) Keflex (cephalexin) Penicillin Sulfas Vancomycin Latex Iodine/Contrast

If so, what is the allergy? _____

Past Medical History:

Please check below if you have, or have had, any of these medical conditions:

- Acid reflux
- Adverse reaction to anesthesia
- Alzheimer's or significant memory loss
- Anemia
- Angina or chest pain
- Arthritis
- Asthma
- Atrial fibrillation or erratic heartbeat
- Bleeding ulcers
- Blood clot in the leg(s) or lung(s)
- Cancer

Type: _____

- Congestive heart failure
- Coronary artery disease
- Dental disease
- Depression
- Diabetes
- Emphysema
- Epilepsy/Seizures
- Fibromyalgia
- Gout
- Hemophilia/Excessive bleeding
- Hepatitis
- High blood pressure

- No past medical problems
- HIV or AIDS
- Infections _____
- Kidney disease
- MRSA
- Osteoporosis
- Peripheral vascular disease
- Pneumonia
- Rheumatoid arthritis
- Stroke (CVA)
- Thyroid disease
- Other not listed, explain:

Surgical History:

Please check below if you have had any of these surgeries:

- Abdominal surgery
- Aneurysm
- Angioplasty/Stents
- Artery bypass of arm or leg
- Bone/Joint surgery

Type: _____

- Breast surgery
- Coronary bypass (CABG)
- Heart valve replacement
- Hysterectomy
- Pacemaker/Defibrillator
- Prostate surgery

- No previous surgery
-
- Other not listed, explain:

Family History:

Please check below if any of your immediate relatives have any of the following:

- Adverse reaction to anesthesia
- Bleeding disorders
- Blood clots/Pulmonary embolism
- Cancer
- Coronary artery disease
- Depression
- Scoliosis

- Diabetes
- Heart disease
- Hypertension
- Osteoporosis
- Rheumatoid arthritis
- Stroke
- Spine disease

- No family medical history to report
- Mental illness
- Kidney disease
- Alcoholism
- Other not listed, explain:

Social History:

Marital Status: Single Married Divorced Widow/Widower

Hobbies _____

Do you dip or chew tobacco? yes no If yes, how much per day? _____

Smoking: Never smoked Former smoker Current smoker How many packs/day? _____

Do you drink alcoholic beverages? yes no If yes, how many drinks per week? _____

Do you use recreational drugs? yes no If yes, what and how often? _____

What is your occupation? _____

Work status: Currently working full duty Light duty Not currently working

Handedness Right Left

Review of Systems

Please check off any current or recent problems you have.

General

- Unexplained weight loss
- Fevers or chills
- Night sweats
- Difficulty sleeping

Ear, Nose, Throat

- Difficulty swallowing
- Loss of hearing
- Ear pain

Eyes

- Glasses
- Change of vision

Cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function
- Leg swelling

Lung

- Shortness of breath
- Productive cough or sputum

Skin

- Frequent rashes
- Frequent itchiness
- Easy bruising

Digestive

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn/acid stomach
- Uncontrolled loss of stool
- Blood in stool

Neurological

- Seizures
- Blackouts/fainting
- Headaches/migraines

Musculoskeletal

- Joint pains
- Joint swelling
- Muscle aches

Genitourinary

- Difficulty starting urination
- Incontinence
- Unable to compley empty bladder

Psychiatric

- Depression
- Nervous exhaustion
- Anxiety

Physician Signature

Date