SPINE INSTITUTE of Arizona

P A T I E N T   Q U E S T I O N N A I R E

Name: ______________________________ Age: __________ Date: __________

JOB DESCRIPTION

Occupation: ________________________ Number of years at this job: ______________

Are you currently working? ❒ YES ❒ NO If so… ❒ Part-time ❒ Full-time

❒ Regular Duty ❒ Modified Duty Working: ________ Hrs/Wk

What are your restrictions, if any? ______________________________________

____

Does your job require you to: (please check all that apply)

❒ Lift or carry greater than 15 lbs. ❒ Bend or twist repetitively.

❒ Work overhead. ❒ Repetitive motion of the arms or legs.

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date Problem/Symptoms Started: ________________

Location of symptoms/pain when the problem started: ______________________________

HOW DID THE PROBLEM START?

❒ Home/Leisure ❒ At Work ❒ Motor Vehicle Accident ❒ Fall ❒ Other: ______________

Please briefly describe: ____

Location of symptoms/pain now: ____

Frequency of symptoms/pain: (please check one)

❒ CONSTANT ❒ INTERMITTENT ❒ RARE

Since the onset of symptoms, has the problem: (please check one)

❒ IMPROVED ❒ WORSENED ❒ STAYED THE SAME

Does coughing or sneezing cause any pain? ❒ YES ❒ NO

If so, where? ____

Do any of the following activities make your symptoms worse? (please check all that apply)

❒ WALKING ❒ LYING ❒ BENDING/TWISTING ❒ WORKING OVERHEAD

❒ SITTING ❒ KNEELING ❒ LIFTING/CARRYING ❒ OTHER: ______________

❒ STANDING ❒ TYPING ❒ PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that makes the pain better:

____

Do you have any weakness, if so, which arm, leg or muscle? ___________________________

Have you had any new or recurrent problems with: Control of urination? ❒ YES ❒ NO

Bowel movements? ❒ YES ❒ NO

Have you experienced recent weight loss or fevers? ❒ YES ❒ NO

Please continue on the other side ☛

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PATIENT SIGNATURE: ______________________________

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED	DATE OF TEST/LOCATION
X-ray	❐ YES ❐ NO	______
MRI Scan	❐ YES ❐ NO	______
CT Scan	❐ YES ❐ NO	______
Bone Scan	❐ YES ❐ NO	______
EMG	❐ YES ❐ NO	______
Other: ______	❐ YES ❐ NO	______

MEDICATIONS *(If yes, please circle the medication below.)*	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories/ Cox-2 Inhibitors	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	❐ YES ❐ NO	❐ YES ❐ NO
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	❐ YES ❐ NO	❐ YES ❐ NO
Pain Medication	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	❐ YES ❐ NO	❐ YES ❐ NO
Oral Steroid	Prednisone, Medrol Dose Pak	❐ YES ❐ NO	❐ YES ❐ NO
Neurontin, Zonegram, Paxil, Amitriptyline, Nortriptyline, Pamelor, Elavil, Prozac		❐ YES ❐ NO	❐ YES ❐ NO
Other	*Please list:* ______	❐ YES ❐ NO	❐ YES ❐ NO

TREATMENTS	RECEIVED	DID THIS HELP?
Physical Therapy/ Exercise	❐ YES ❐ NO	❐ YES ❐ NO
Chiropractic Care	❐ YES ❐ NO	❐ YES ❐ NO
Injections in Muscle or other injections in office	❐ YES ❐ NO	❐ YES ❐ NO
Epidural Steroid Injections	❐ YES ❐ NO	❐ YES ❐ NO
Facet Blocks	❐ YES ❐ NO	❐ YES ❐ NO
Braces/Corsets	❐ YES ❐ NO	❐ YES ❐ NO

Back Surgery: ❐ Cervical ❐ Thoracic ❐ Lumbar When: ______

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine? ❐ YES ❐ NO If yes, please list…

PHYSICIAN NAME	MONTH/YEAR OF TREATMENT

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? ❐ YES ❐ NO

If yes, please list your attorney's name: ______

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