VERMONT ORTHOPAEDIC CLINIC
SPINE QUESTIONNAIRE

Please answer all questions.

Date of visit: _____ Height: _____ Weight:_____

Name:_____ Date of birth:_____

Age:_____ What hand do you write with?_____

Referring Doctor:_____

Primary Doctor:_____

Is this a work related injury? Yes _____ No_____

Where is your pain? _____

When did your pain begin?_____

What do you think caused the pain?_____

_____

Describe how and when these problems started:_____

_____

_____

Since it started, is the pain: Increasing _____ Decreasing _____ Same _____

Have you had any other spinal pain before this episode? Yes _____ No_____

Describe:_____

_____

Have you ever had surgery on your neck or back before? Yes _____ No_____

Please list below:

Date	Surgeon	What Operation	Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please fill out the appropriate sections: Neck pain or Back pain.
If you have both, please fill out both.

NECK PAIN

Does the neck pain: Come and go _____ or Always present _____

Is the pain in your neck: Sharp like a knife _____ Aching pain _____ Other _____

Describe:_____

What makes the pain worse? _____

What makes the pain better? _____

Do you have pain in the arms? Yes _____ No _____

Which arm? Right _____ Left _____ Both _____

Does the arm pain: Come and go _____ or Always present _____

Does the pain go below the elbow? Yes _____ No _____

Which part of the arm is painful? Inside ____Outside ____Back ____Front____

Which part of the forearm is painful? Inside ___Outside ___Back ___Front___

Which part of the hand is painful? Top ____Bottom ____Inside ____Outside____

Do your arms get numb? Yes _____ No _____

Which areas: _____

Do your arms get weak? Yes _____ No _____

Which areas: _____

What bothers you more? Neck _____ Arms_____ Equal _____

On a scale of 0 to 10, with 0 being no pain and 10 being the most painful, how bad is

your **NECK PAIN**: on the average _____ at its worst _____

your **ARM PAIN**: on the average _____ at its worst _____

BACK PAIN

Does the back pain: Come and go _____ or Always present _____

Is the pain in your back: Sharp like a knife _____ Aching pain _____ Other _____

Describe:_____

What makes the pain worse? _____

What makes the pain better? _____

Do you have pain in your legs? Yes _____ No _____

Which leg? Right _____ Left _____ Both _____

Does the pain go below the knees? Yes _____ No _____

Which part of the thigh is painful? Inside ____Outside ____Back ____Front____

Which part of the calf is painful? Inside ____Outside ____Back ____Front____

Which part of the foot is painful? Top ____Bottom ____Inside ____Outside____

Do your legs get numb? Yes _____ No _____

Do your legs get weak? Yes _____ No _____

What bothers you more? Back _____ Legs_____ Equal _____

On a scale of 0 to 10, with 0 being no pain and 10 being the most painful, how bad is

your **BACK PAIN**: on the average _____ at its worst _____

your **LEG PAIN**: on the average _____ at its worst _____

GENERAL

What activities have you stopped because of this pain? _____

_____

_____

Do you have full control of your bowels and bladder? Yes _____ No _____

If no, please describe: _____

_____

Do you often lose your balance and feel clumsy? Yes _____ No _____

If yes, please describe: _____

_____

What is the farthest distance you can walk? _____

What stops you? _____

Is the pain bad enough that you would consider surgery for some relief? Yes ____No___

What other doctors, clinics, emergency rooms, or hospitals have you seen for your current spinal problem?

Name Address Date of First Visit Date of Last Visit

_____

_____

_____

Have you had Physical Therapy for you back/neck pain? Yes _____ No _____

When was the last time you went? _____

How long did you go to therapy? _____

What types of therapy did they do? _____

_____

Did therapy help? A lot ____ A little ____ Temporary ____ None ____

Have you had Chiropractic Care for your back/neck pain? Yes _____ No _____

When was the last time you went? _____

How long did you go to chiropractor care? _____

Did chiropractic care help? A lot ____ A little ____ Temporary ____ None ____

Have you seen a pain management specialist for your back/neck pain?Yes ____No _____

Have you had epidural spinal injections for you back/ neck pain? Yes ____No _____

Did they help? Yes _____ No _____

How many have you had? _____ How long did they last for? _____

When was the last one? _____

What medications have you taken for your back/neck pain?

Drug Dose How many a day? Last time taken

_____

_____

_____

_____

_____

Have you had X-rays for you back/neck pain? Yes____ No _____

When was it done? _____ Where was it done? _____

Have you had a MRI (Magnetic resonance image) for your back/neck pain? Yes__No__

When was it done? _____ Where was it done? _____

What other tests have you had done for your back/neck pain?

Test	Date	Where

Personal/Family Medical History-please indicate specific disease and which family member if applicable

	Self	Family	Comments
Lung Disease	_____	_____	_____
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Arthritis	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Cancer	_____	_____	_____
Bleeding problems	_____	_____	_____
Concussion	_____	_____	_____
Other	_____	_____	_____

List any previous surgery (and dates):_____
_____

WORK/SOCIAL HISTORY

When did you last work or do normal activities? _____

Have you returned to work? Yes____ No _____ If yes, date _____

Have you been released back to work?Yes____No ____ If yes, date_____

What restrictions are you currently on? _____

How long have you had your most recent job? _____

List your hobbies and recreational activities: _____

_____

Do you smoke? Yes____ No _____ If yes, how much? _____

Did you ever smoke? Yes____ No _____ If yes, when did you quit?_____

Do you drink any alcohol? Yes____ No _____ If yes, how much?_____

Do you currently use recreational drugs? Yes____ No _____

Have you used recreational drugs in the past? Yes_____ No _____

If yes, what drugs? _____