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## NEW SPINE PATIENT QUESTIONNAIRE

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**Patient Name (please print)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Age** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Gender: Male Female**

**Primary Care Doctor** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Referring Doctor** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**We routinely send a copy of all clinic notes to your primary doctor and referring doctor. Please let us know if there is someone else you would like to send a copy.**

**Please bring any prior imaging (Xray, MRI, CT) on a disc and any related reports to your appointment.**

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We know that filling out these forms can be difficult, but please complete them carefully.

It will give us a better understanding of you and your problem and enable us to provide you the best possible medical care.

Thank you for your cooperation.

Aaron Kunkle, DO  
Fort Wayne Orthopedics

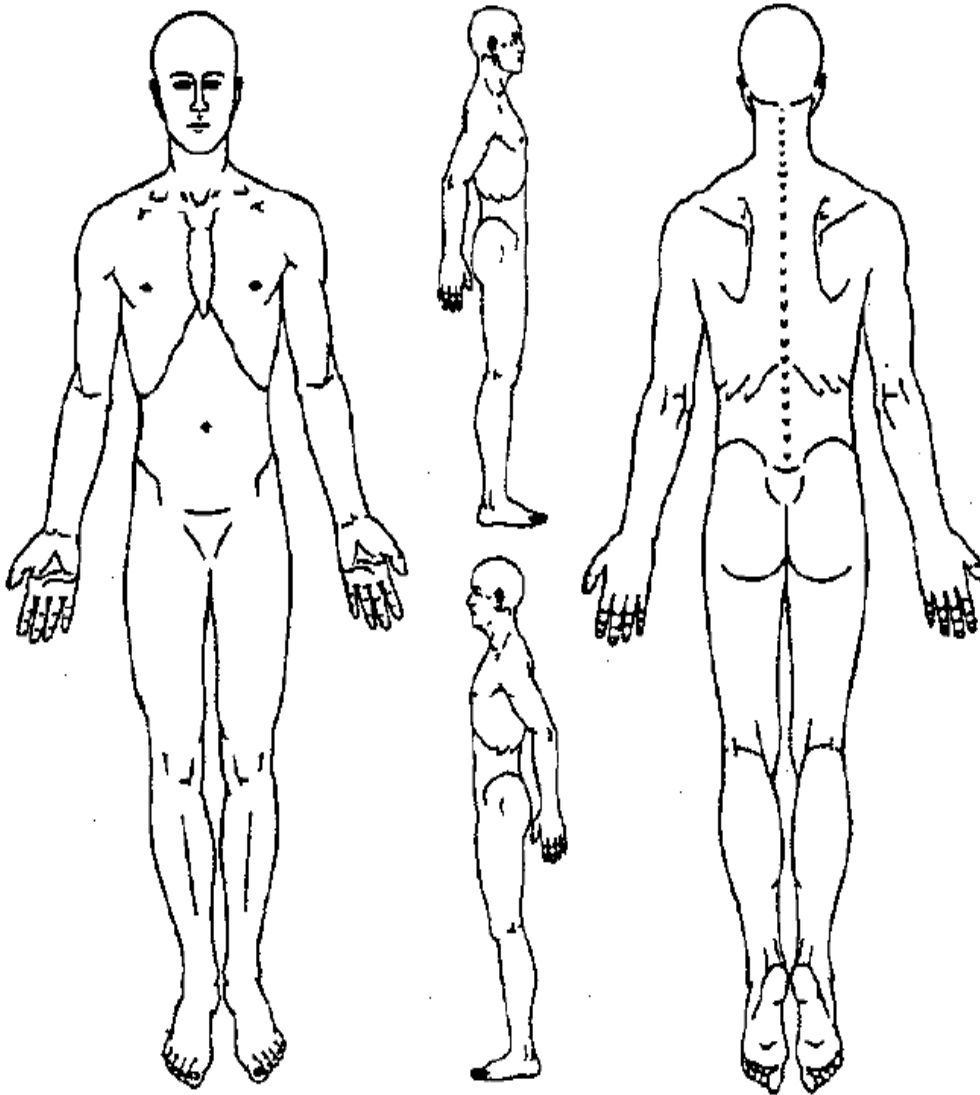
**For office use only:**

**Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_ **BMI** \_\_\_\_\_ **HR** \_\_\_\_\_

## PAIN DIAGRAM

Please mark the areas where you experience the following sensations:

<u>Ache</u> XXXXXX	<u>Numbness</u> OOOOO	<u>Pins &amp; Needles</u> =====	<u>Burning</u> AAAAAAAA	<u>Stabbing</u> /////////
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## HISTORY OF PRESENT ILLNESS

### How and when did your BACK or NECK problem begin?

Injury (date of injury \_\_\_\_\_)

Explain how the injury happened: \_\_\_\_\_

On-the-job

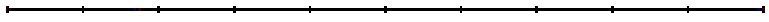
I don't know how it began

I've had it for about \_\_\_\_\_ weeks/months/years (circle one)

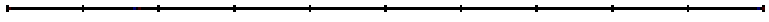
It comes and goes OR  It is constant

Draw a vertical line like this  on the lines below to show your severity of pain today.

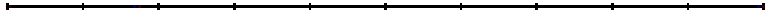
How bad is your low back pain?

No pain  Worst possible pain

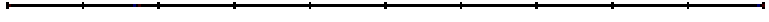
How bad is your leg pain?

No pain  Worst possible pain

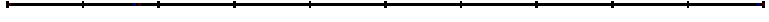
How bad is your upper back pain?

No pain  Worst possible pain

How bad is your neck pain?

No pain  Worst possible pain

How bad is your arm pain?

No pain  Worst possible pain

For patients with NECK or ARM pain, numbness or weakness (*skip to next page if you have none*):

When comparing your neck pain to your arm pain: (Please check one box)

Neck Pain vs. Arm Pain		
✓	% Neck Pain	% Arm Pain
<input type="checkbox"/>	100%	0%
<input type="checkbox"/>	75%	25%
<input type="checkbox"/>	50%	50%
<input type="checkbox"/>	25%	75%
<input type="checkbox"/>	0%	100%

Raising the arm:  improves the pain  worsens the pain  no change

Moving the neck:  improves the pain  worsens the pain  no change

There is:  weakness  NO weakness in the arms or hands

There is:  numbness or tingling  NO numbness or tingling in the arms or hands

Have you noticed clumsiness, difficulty buttoning buttons or picking up small objects like coins?  No  Yes

Have you noticed balance problems or do you trip easily?  No  Yes

**For patients with BACK or LEG pain, numbness or weakness (skip if you have none):**

**When comparing your back pain to your leg pain:** (Please check one box)

Back Pain vs. Leg Pain		
✓	% Back Pain	% Leg Pain
<input type="checkbox"/>	100%	0%
<input type="checkbox"/>	75%	25%
<input type="checkbox"/>	50%	50%
<input type="checkbox"/>	25%	75%
<input type="checkbox"/>	0%	100%

Do you have pain that goes below your knees?  No  Yes

There is weakness of my:

LEFT:  thigh  calf  ankle  foot  toe  no weakness

RIGHT:  thigh  calf  ankle  foot  toe  no weakness

There is numbness of my:

LEFT:  thigh  calf  ankle  foot  toe  no numbness

RIGHT:  thigh  calf  ankle  foot  toe  no numbness

The worst position for your pain is:  sitting  standing  walking

How many minutes can you STAND in one place without pain?  0-10  15-30  30-60  60+

How many blocks can you WALK without having to stop and rest due to pain?

less than 1  1-3  1 mile  2 miles or more

Lying down:  eases my pain  makes it worse  no change

Bending forward:  eases my pain  makes it worse  no change

**ALL PATIENTS please answer the following:**

Does coughing or sneezing worsen your pain?  No  Yes

There is:  NO loss of bowel or bladder control

Loss of control since \_\_\_\_\_, please describe: \_\_\_\_\_

Prior to my neck/back problem starting, I was:

working full-time (Occupation: \_\_\_\_\_)

working part-time (Occupation: \_\_\_\_\_)

disabled, not working

not working by choice (retired, student, etc)

I have:  not missed any work because of this problem  missed work (how much? \_\_\_\_\_)

been out of work since \_\_\_\_\_

Because of this back/neck problem, do you have or plan to have:

lawsuit  worker's compensation claim  unsure  none

### Previous SPINE Testing

			If yes, date of most recent test:
X-rays	No	Yes	_____
MRI scan	No	Yes	_____
CT scan	No	Yes	_____
Myelogram	No	Yes	_____
Discogram	No	Yes	_____
Bone Density Study	No	Yes	_____
Nerve test (EMG/NCV)	No	Yes	_____

### Previous SPINE Treatments

Treatments so far for my BACK or NECK problem include:

- Physical therapy (How many visits?\_\_\_\_\_ Last visit?\_\_\_\_\_)
- Chiropractic care (How many visits?\_\_\_\_\_ Last visit?\_\_\_\_\_)
- Epidural injections or nerve blocks (How many times?\_\_\_\_\_ How long did they help?\_\_\_\_\_)
- Anti-inflammatory medications (e.g. Motrin, Advil, Aleve, ibuprofen, naproxen)
- Narcotic medication (e.g. Tylenol #3, hydrocodone, oxycodone)
- Massage       TENS unit       Braces       Psychological consultation
- Other: \_\_\_\_\_

Are there any other non-surgical treatments that you would like to try? \_\_\_\_\_  
 \_\_\_\_\_

### Previous doctors you have seen for your back/neck problem:

Doctor	Specialty	City
_____	_____	_____
_____	_____	_____

Have you ever had surgery on your **SPINE**?     No     Yes    **If yes, complete the following:**

Type of surgery _____	Type of surgery _____
When _____	When _____
Surgeon _____	Surgeon _____

Did it help your pain?     No     Yes                      Did it help your pain?     No     Yes

**Some patients who continue to have disabling pain and/or limited function due to their back/neck problem and who have tried all non-surgical options without relief may benefit from surgery. However, surgery does have significant risks such as: 1% or less risk of major complications (including heart attack, stroke, paralysis, clot to the lungs, death) as well as 5-15% risk of lesser complications (including bleeding, infection, worsening symptoms, bowel or bladder problems, blood clots in legs, spinal fluid leak, spinal implant failure). Other risks may apply to your specific problem.**

**Do you feel that your problem limits your activities enough or causes you enough pain that you would consider having surgery?**     No     Yes

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## REVIEW OF SYSTEMS

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**Do you have any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Recent weight loss more than 10 pounds            | <input type="checkbox"/> Rash                                      |
| <input type="checkbox"/> Recent weight gain more than 10 pounds            | <input type="checkbox"/> Open sores                                |
| <input type="checkbox"/> Fever or chills                                   | <input type="checkbox"/> New moles                                 |
| <input type="checkbox"/> Night sweats                                      | <input type="checkbox"/> Skin infection                            |
| <br>   |  |
| <input type="checkbox"/> Eye problems                                      | <input type="checkbox"/> Toothache                                 |
| <input type="checkbox"/> Sore throat                                       | <input type="checkbox"/> Nosebleeds                                |
| <input type="checkbox"/> Hoarseness  | <input type="checkbox"/> Easy bleeding or bruising                 |
| <input type="checkbox"/> Difficulty swallowing                             | <input type="checkbox"/> Poor healing                              |
| <br>   |  |
| <input type="checkbox"/> Heart or chest pain                               | <input type="checkbox"/> Joint pain or swelling in many joints     |
| <input type="checkbox"/> Abnormal heartbeat                                | <input type="checkbox"/> General body weakness or fatigue          |
| <input type="checkbox"/> Leg/feet swelling                                 | <input type="checkbox"/> Feeling hot or cold all the time          |
| <input type="checkbox"/> Leg/foot ulcer                                    | <input type="checkbox"/> Calf cramps when walking                  |
| <br>   |  |
| <input type="checkbox"/> Wheezing  | <input type="checkbox"/> Bladder infection                         |
| <input type="checkbox"/> Difficulty breathing                              | <input type="checkbox"/> Pain with urination                       |
| <input type="checkbox"/> Cough   | <input type="checkbox"/> Getting up frequently at night to urinate |
| <input type="checkbox"/> Shortness of breath                               | <input type="checkbox"/> Difficulty starting urination             |
|  | <input type="checkbox"/> Males: erection problems                  |
| <br>   |  |
| <input type="checkbox"/> Stomach pain                                      | <input type="checkbox"/> Feelings of hopelessness or crying spells |
| <input type="checkbox"/> Heartburn   | <input type="checkbox"/> Poor appetite                             |
| <input type="checkbox"/> Nausea or Vomiting                                | <input type="checkbox"/> Headaches                                 |
| <input type="checkbox"/> Diarrhea or <input type="checkbox"/> Constipation | <input type="checkbox"/> Tremors                                   |
| <input type="checkbox"/> Black tar-like or bloody stools                   | <input type="checkbox"/> Insomnia                                  |

Is your primary care doctor aware of all of the above checked problems?  No  Yes

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## GENERAL MEDICAL HISTORY

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**Do you have or have you ever had any of the following conditions? (Please circle)**

- |                                 |                              |                                     |
|---------------------------------|------------------------------|-------------------------------------|
| Anemia                          | Enlarged prostate            | Lupus/immune disorder               |
| Asthma                          | Fibromyalgia                 | Osteoarthritis                      |
| Bleeding Tendency               | Gastric reflux/stomach ulcer | Osteoporosis                        |
| Blood clot in leg – phlebitis   | Gout                         | Other psychiatric problems          |
| Blood clot in lung              | Heart attack/Angina          | Previous oral steroids (prednisone) |
| Cancer – Type _____             | Heart failure                | Previous fractures                  |
| Colitis                         | Hepatitis – liver failure    | Psoriasis                           |
| Depression/Anxiety              | High blood pressure          | Rheumatoid arthritis                |
| Diabetes – Type 1 __, Type 2 __ | High cholesterol             | Sleep apnea                         |
| Drug/Alcohol dependence         | Intestinal problems          | Stroke/TIA's                        |
| Epilepsy/Seizures               | Kidney disease/stones        | Thyroid problems                    |
| Emphysema/COPD                  | Lung problems                | Tuberculosis                        |

**Please list any surgery you have had OTHER THAN SPINE SURGERY.**

Type of Surgery	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**MEDICATIONS**

**Please list all medication you take including prescription, nonprescription, herbal and vitamins.**

I do not take any medication

Medication	Reason taken	Dose & How often	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Any ALLERGIES to medications, foods, tape, latex or iodine/betadine?**  No  Yes

**If yes, please list and describe reaction.** \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

I do not know the medical history of my biological parents or other family members (go to next section)

Mother:  My mother is alive and is \_\_\_\_ years old  
 She is in good health  She suffers with \_\_\_\_\_  
 My mother is deceased at age \_\_\_\_ Cause \_\_\_\_\_

Father:  My father is alive and is \_\_\_\_ years old  
 He is in good health  He suffers with \_\_\_\_\_  
 My father is deceased at age \_\_\_\_ Cause \_\_\_\_\_

I have \_\_\_\_ living brothers/sisters.

I have \_\_\_\_ deceased brothers/sisters. Cause(s) \_\_\_\_\_

Members of my family (biological parents, brothers/sisters, grandparents, aunts/uncles) have been diagnosed with the following (please circle all that apply):

- |                     |                       |                   |
|---------------------|-----------------------|-------------------|
| Stroke              | Back problems         | Arthritis         |
| Diabetes            | Scoliosis or Kyphosis | Bleeding problems |
| Lung disease        | Kidney problems       | Other _____       |
| High blood pressure | Cancer                | None of these     |
| Heart trouble       | Osteoporosis          |                   |

## **SOCIAL HISTORY**

**Marital Status (circle one answer)**    married    single    separated    divorced    widow/widower

**Smoking:** Do you, or have you ever, smoked?     No     Yes - If yes, please complete the following:

I smoke \_\_\_\_\_ packs per day and I have smoked for \_\_\_\_\_ years.

I did smoke \_\_\_\_\_ packs per day, but I quit smoking \_\_\_\_\_ years ago.

Do you, or have you ever, used vaping products?     No     Yes

Do you use any other smokeless tobacco products?     No     Yes

**Alcohol:** Do you drink?     No     Yes - If yes, how much:     Daily     Occasionally     Never

**Education (circle the highest level of education you completed)**

Grammar School

High school

College

Post-graduate

**Advance Directive?**     No     Yes

**Medical Power of Attorney?**     No     Yes

**THANK YOU.**

Patient's initials \_\_\_\_\_ Date \_\_\_\_\_