NEW SPINE PATIENT QUESTIONNAIRE

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.

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

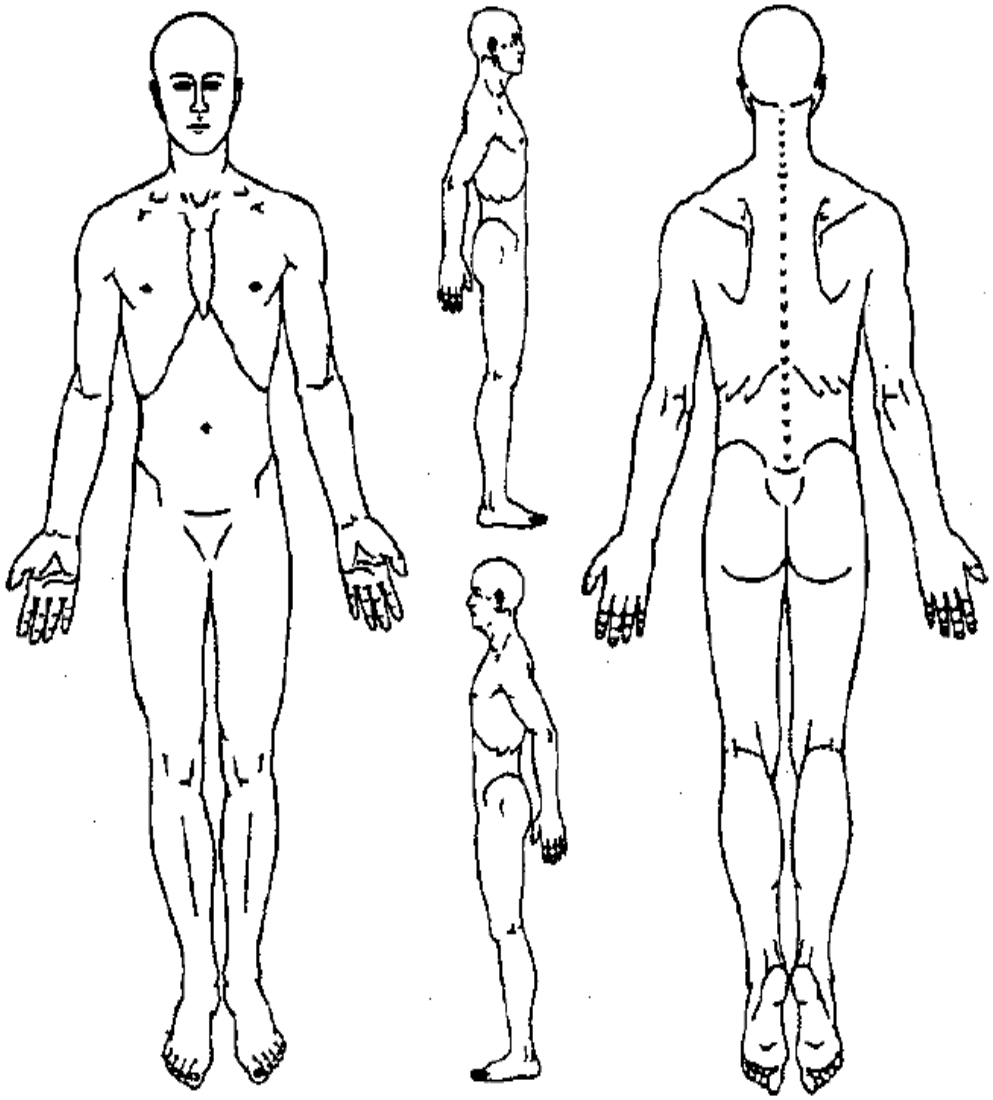
For office use only:

Ht_____ Wt_____BMI _____HR_____

PAIN DIAGRAM

Please mark the areas where you experience the following sensations:

Ache	Numbness	Pins & Needles	Burning	Stabbing
XXXXXX	OOOOO	========	^^^^^^^^	///////////



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
	100%	0%
	75%	25%
	50%	50%
	25%	75%
	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
	100%	0%
	75%	25%
	50%	50%
	25%	75%
	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 <u>SPINE</u>? ❑ 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

REVIEW OF SYSTEMS

Do you have any of the following?

- ❑ Recent weight loss more than 10 pounds
- ❑ Recent weight gain more than 10 pounds
- ❑ Fever or chills
- ❑ Night sweats

- ❑ Rash
- ❑ Open sores
- ❑ New moles
- ❑ Skin infection

- ❑ Eye problems
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing

- ❑ Toothache
- ❑ Nosebleeds
- ❑ Easy bleeding or bruising
- ❑ Poor healing

- ❑ Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Leg/feet swelling
- ❑ Leg/foot ulcer

- ❑ Joint pain or swelling in many joints
- ❑ General body weakness or fatigue
- ❑ Feeling hot or cold all the time
- ❑ Calf cramps when walking

- ❑ Wheezing
- ❑ Difficulty breathing
- ❑ Cough
- ❑ Shortness of breath

- ❑ Bladder infection
- ❑ Pain with urination
- ❑ Getting up frequently at night to urinate
- ❑ Difficulty starting urination
- ❑ Males: erection problems

- ❑ Stomach pain
- ❑ Heartburn
- ❑ Nausea or Vomiting
- ❑ Diarrhea or ❑ Constipation
- ❑ Black tar-like or bloody stools

- ❑ Feelings of hopelessness or crying spells
- ❑ Poor appetite
- ❑ Headaches
- ❑ Tremors
- ❑ Insomnia

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

GENERAL MEDICAL HISTORY

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____ _____