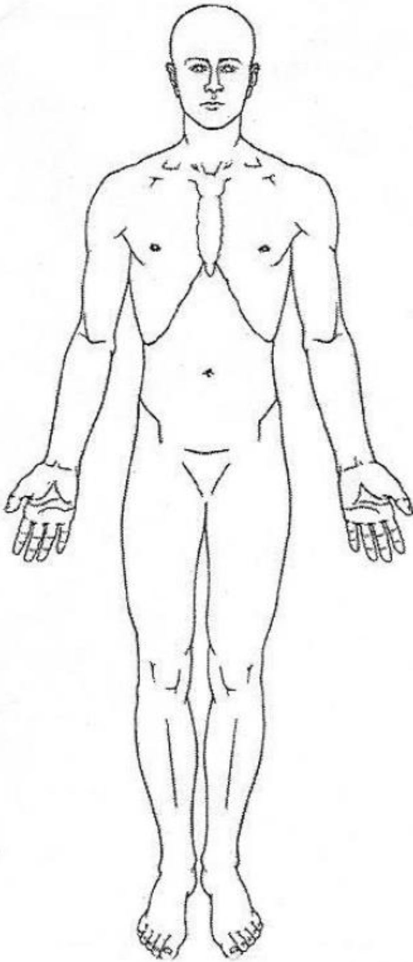
Arch Health Partners
Orthopedics

Patient Name: ____________________
DOB: ____________________
MRN: ____________________

Spine Surgery Questionnaire

Date: ____________________ Height: ____________________
Age: ____________________ Weight: ____________________

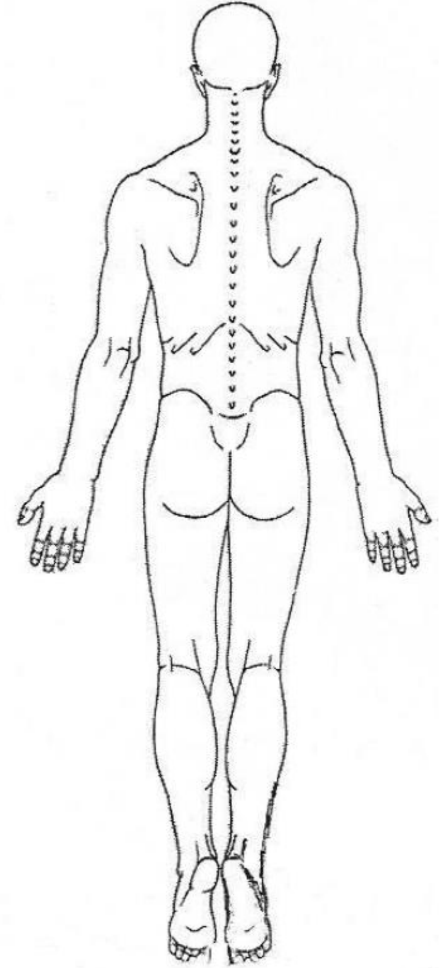


Please indicate the percentage of pain that you currently feel

Lower Extremity Pain	%
Upper Extremity Pain	%
Neck Pain	%
Back Pain	%
Total	**100%**

Use the body diagrams to show where you feel the following sensations

XXX	Burning
AAA	Dull ache
000	Numb
///	Stabbing
***	Stiffness
---	Tingling



Please place an **X** on the hash mark that most accurately describes your overall degree of pain now.

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1. **What is the main reason for your visit today? (Check all that apply)**
   ☐ Back Pain ☐ Leg Pain ☐ Neck Pain ☐ Arm Pain ☐ Other: ____________

2. **How long has this been a problem?** Date of Injury: ____________
   If no date of injury, please estimate when symptoms started.
   ☐ Less than 2 months ☐ 2-6 months ☐ 6-12 months ☐ Greater than 1 year

3. **Have you been treated by another caregiver for your symptoms?**
   ☐ No One ☐ Chiropractor ☐ Other: ________
   ☐ Medical Doctor ☐ Physical Therapist ☐ Other: ________

4. **What treatment have you received for this problem?**
   ☐ Nothing ☐ Chiropractic Care ☐ Acupuncture ☐ Injections
   ☐ Physical Therapy
   - ☐Stretching ☐Strengthening ☐Traction ☐Iontophoresis/Topical Steroid
   - ☐Massage ☐Ultrasound ☐Heat/Ice ☐Therapeutic Ball ☐TENS

   ☐ Medications
   - ☐Muscle Relaxants ☐Pain Medications ☐Anti-Inflammatory (Rx)
   - ☐Anti-Inflammatory (OTC) (Aspirin, Tylenol, Aleve, Advil, etc.)

   ☐ Other: ____

5. **Have you had any tests for this problem?**
   ☐ Xrays ☐ MRI ☐ Discography ☐ EMG
   ☐ CT/Myelogram ☐ Bone Scan ☐ CT
   ☐ Other: __________

6. **Current problem is the result of: (Check all that apply)**
   ☐ Injured at work If so, date last worked? ____________ ☐ Auto Accident ☐ Sports
   ☐ No apparent cause ☐ Other: ______________________________

7. **Current problem began: (Check all that apply)**
   ☐ Suddenly ☐ Gradually ☐ Lifting ☐ Fall
   ☐ Bending ☐ Pulling ☐ Twisting ☐ Other ________

8. **What makes the pain worse? (Check all that apply)**
   ☐ During Exercise ☐ After Exercise ☐ Prolonged Sitting ☐ Prolonged Standing
   ☐ Bending Forward ☐ Bending Backward ☐ Pushing ☐ Pulling
   ☐ Night Pain ☐ Squatting ☐ Walking ☐ Other ________

9. **What reduces your pain? (Check all that apply)**
   ☐ Nothing ☐ Lying Down ☐ Sitting ☐ Walking
   ☐ Medication ☐ Changing Positions ☐ Standing ☐ Other ________

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Past Medical History

1. **Spine Surgical History:**

Date	Surgery	Complications (if any)

2. **Other Surgical History:**

Date	Surgery	Complications (if any)

3. **Current or Past Illnesses:**

Date	Illness or hospitalization

4. **List any allergies to medication:** **Are you allergic to Latex?** ☐ Yes ☐ No

____

____

____

5. **List all prescriptions or over the counter medications you are currently taking:**

Medication	Strength	Instructions

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Social History

1. **Age:** ______________
2. **Occupation:** ______________________________
   What is your current employment status?
   ☐ Full-time ☐ Retired ☐ Unemployed
   ☐ Part-time ☐ Self-employed ☐ Other: __________
3. **Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
4. **Do you have children?** ☐ Yes ☐ No If yes, how many: ____________
5. **Do you live alone?** ☐ Yes ☐ No
6. **How often do you exercise?** ☐Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
   Type of exercise/activity? ______________________________
7. **Do you have lots of stairs?** ☐ Yes ☐ No
8. **Do you smoke?** ☐ Yes ☐ No If yes, ______ packs per day for _____ years
   Have you quit smoking? ☐ Yes ☐ No If yes, how long ago? ___________
9. **Do you use other nicotine products?** ☐ Yes ☐ No
   Which product do you use?
   ☐ Chew ☐ Gum ☐ Patch ☐ Cigars ☐ Other ___________
10. **Do you drink alcohol?** ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ Socially ☐ Never

Family History

1. **Do you have a family history of:**

Arthritis	☐ Yes	☐ No	Blood clots/excessive bleeding	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Adverse reaction to anesthesia	☐ Yes	☐ No
Mental Health Disorders	☐ Yes	☐ No	Cardiac Disorders	☐ Yes	☐ No

Other: ______________________________

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Spine Surgery Questionnaire

Review of Systems

Are you currently or have you had problems with:

			Please describe all "yes" answers
Skin	☐ Yes	☐ No	
Ears, Nose and Throat	☐ Yes	☐ No	
Cardiac/High Blood Pressure	☐ Yes	☐ No	
Lungs (Asthma, Infection)	☐ Yes	☐ No	
Stomach/Digestion	☐ Yes	☐ No	
Bladder/Bowel Problems	☐ Yes	☐ No	
Hematologic/Bleeding Problems	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Musculoskeletal	☐ Yes	☐ No	
Neurological	☐ Yes	☐ No	
Psychiatric Problems	☐ Yes	☐ No	
Reproductive/Sexual Problems	☐ Yes	☐ No	
Fever/Chills	☐ Yes	☐ No	
Night Sweats	☐ Yes	☐ No	
Night Pain	☐ Yes	☐ No	
Unexpected Weight Loss	☐ Yes	☐ No	