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Diagnosis and non-surgical treatment of spine disorders, including diagnostic and therapeutic injections and interventional pain management

Spine Health Questionnaire

Our job is to diagnose the cause of your spinal problem and treat it as best as possible. By completely filling out this questionnaire you will help us do that.

Although you may not even realize it, various aspects of your life may be contributing to your problem. The following questions are about aspects of your work and lifestyle that may be affecting your spine.

1. What is your current work situation?
- ☐ Employed, working
- ☐ Employed, temporarily disabled
- ☐ Unemployed
- ☐ Retired
- ☐ Homemaker or stay-at-home parent
- ☐ Long-term disability (related to back or neck problem)
- ☐ Long-term disability (related to another problem)

2. What is your occupation? If retired, on long-term disability, or unemployed provide your occupation while you were working.

_____

_____

3. Describe the physical demands associated with your occupation (include travel demands such as commuting):

_____

_____

_____

_____

4. Are you:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow or widower
- ☐ In a domestic partnership

5. Who are the members of your household? Provide relationship and age for each member (e.g., wife, age 50, son age 7).

_____

_____

_____

_____

_____

6. Do you normally (if your back or neck is not hurting too much) exercise or play sports regularly?
- ☐ No
- ☐ Yes, Describe: _____

_____

_____

7. Do you have any hobbies, pastimes, or special interests?
- ☐ No
- ☐ Yes, Describe: _____

_____

_____

8. Are there any recent life changes or stressful events (e.g., job change, relationship change, family illness)?
- ☐ No
- ☐ Yes, Describe: _____

_____

_____

9. Do you drink alcohol?
- ☐ No
- ☐ Yes, How much and how often: _____

_____

_____

10. Have you ever smoked?
- ☐ No
- ☐ Yes, # years_____ # packs/day_____
  Date quit (if you have): _____

11. Do you use any recreational drugs (e.g. marijuana)?
- ☐ No
- ☐ Yes, Which one(s) and how often: _____

_____

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The next series of questions are about your CURRENT EPISODE of symptoms.

1. Describe the symptoms that you are seeking help for in one sentence (for example, "my back hurts").

_____

2. When did this problem start?_____ How did this problem start and what do you think caused it?

_____

_____

_____

3. Have you seen any of the following types of doctors for your current episode?

Y	N	Specialty	Name(s)	Y	N	Specialty	Name(s)
☐	☐	Primary care	_____	☐	☐	Chiropractor	_____
☐	☐	Occupational Medicine	_____	☐	☐	Orthopedic surgeon	_____
☐	☐	Emergency Room	_____	☐	☐	Neurosurgeon	_____
☐	☐	Neurology	_____	☐	☐	Pain management	_____
☐	☐	Physiatrist	_____	☐	☐	Other	_____

4. Have you had any of the following treatments?

Y	N		Effect on symptoms (circle best response)			Comments (e.g. "made me drowsy")
☐	☐	Non-steroidal anti-inflammatory[a]	Better	Worse	No change	_____
☐	☐	Muscle relaxants[b]	Better	Worse	No change	_____
☐	☐	Pain medications[c]	Better	Worse	No change	_____
☐	☐	Nerve pain medication[d]	Better	Worse	No change	_____
☐	☐	Anti-depressant[e]	Better	Worse	No change	_____
☐	☐	Oral steroids	Better	Worse	No change	_____
☐	☐	Physical therapy	Better	Worse	No change	_____
☐	☐	Acupuncture	Better	Worse	No change	_____
☐	☐	Chiropractic care	Better	Worse	No change	_____
☐	☐	Injections	Better	Worse	No change	_____
☐	☐	Surgery	Better	Worse	No change	_____
☐	☐	Other	Better	Worse	No change	_____

a. E.g. , Tyelenol, ibuprofen (Advil, Motrin), naproxen (Alleve), Celebrex, nabumetone (Relafen), meloxicam (Mobic).
b. E.g., cyclobenzaprine (Flexeril), carisoprodol (Soma), methocarbamol (Robaxin), metaxalone (Skelaxin), baclofen
c. E.g., tramadol (Ultram), codeine, hydrocodone (Vicodin, Norco), oxycodone (Percocet, Oxycontin), Fiorinal/Fioricet, morphine (morphine elixir, MS contin), fentanyl (Duragesic patch), Dilaudid.
d. E.g. gabapentin (Neurontin), Lyrica, Topamax, mexilitene
e. E.g. amitryptaline (Elavil), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), Cymbalta

5. Are your symptoms:

☐ Improving ☐ Unchanging ☐ Worsening

6. Have your work activities been affected?

☐ No

☐ Yes, Restrictions: _____

Amount of work missed_____

7. Has your ability to do household chores been affected?

☐ No

☐ Yes, Describe_____

_____

8. Has your ability to exercise, play sports or do other recreational acitivities (including hobbies and pastimes) been affected?

☐ No

☐ Yes, Describe _____

_____

_____

_____

9. What do you fear most about your problem?_____

_____

_____

_____

Previous spine problems, as well as problems with other bones and joints (e.g. shoulder, elbow, wrist, hands, hip, knee, ankle, feet), may affect your current spine problem. In the following table provide information on any prior problems you have had with your spine or other bones and joints.

Problem Area (e.g. back, neck, hip, shoulder)	**Date of onset**	**Cause** (if known)	**Treatments received** (e.g. PT, meds, surgery)	**Time off work**	**Complete recovery?** (Y/N)

There are a number of factors that may affect pain.

1. Have you ever been diagnosed with any of the following?

Y	**N**		**Y**	**N**	
☐	☐	Irritable bowel syndrome	☐	☐	Chemical Dependency
☐	☐	Migraines	☐	☐	Alcoholism
☐	☐	Fibromyalgia	☐	☐	Depression
☐	☐	Neuropathy	☐	☐	Bipolar
☐	☐	RSD	☐	☐	PTSD
☐	☐	Tension headaches	☐	☐	Lupus
☐	☐	TMJ syndrome	☐	☐	Atypical (non-heart related) chest pain
☐	☐	HIV	☐	☐	Interstitial (non-infectious) cystitis
☐	☐	Rheumatoid arthritis			

2. Pain can affect your mood, and your mood can affect pain. Have you had any of the following symptoms recently?

Y	**N**		**Y**	**N**	
☐	☐	Anxiety/Nervousness	☐	☐	Crying spells
☐	☐	Low or blue moods	☐	☐	Feeling hopeless
☐	☐	Irritibility			

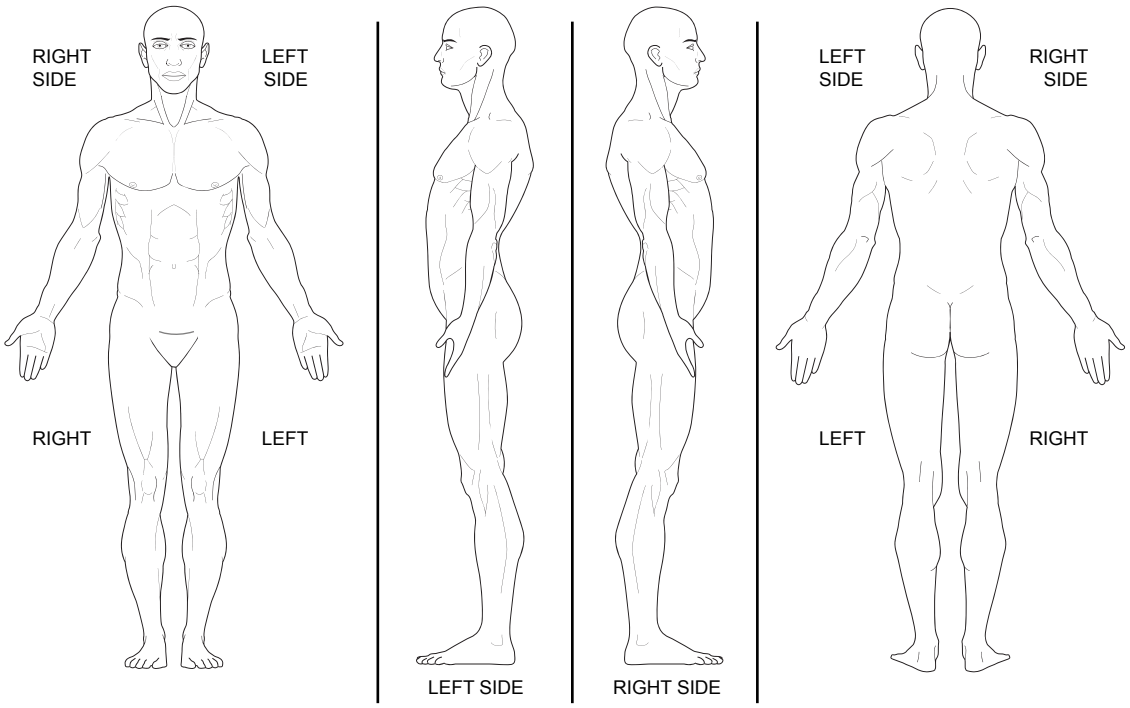
3. Back and neck problems sometimes run in families. Have any family members had spinal problems?

☐ No

☐ Yes, Describe_____

The better we understand your symptoms the better we can treat them. In this section please describe your symptoms as best as you can.

1. Mark the location of your **pain with an X**, and any **numbness or tingling with an O**.



2. Select all of the words that describe your pain.

- ☐ Aching
- ☐ Cramping
- ☐ Stabbing
- ☐ Sharp
- ☐ Throbbing
- ☐ Burning
- ☐ Electrical
- ☐ Other Describe:_____

_____
_____
_____
_____
_____
_____

3. Place a mark on the line that represents your level of pain **TODAY**

0 ——— 10

4. Place a mark on the line that represents your level of pain **IN THE LAST WEEK**

0 ——— 10

5. Indicate how bothersome each of the following symptoms is.

	Not at all bothersome	**Slightly bothersome**	**Moderately bothersome**	**Very bothersome**	**Extremely bothersome**
Back pain	☐	☐	☐	☐	☐
Leg pain	☐	☐	☐	☐	☐
Neck pain	☐	☐	☐	☐	☐
Arm pain	☐	☐	☐	☐	☐

6. Indicate the effect of these activities on your symptoms.

Activity	**Effect on symptoms** (circle best response)			**Comments**
Sitting	Better	Worse	No change	_____
Getting up from sitting	Better	Worse	No change	_____
Standing	Better	Worse	No change	_____
Walking	Better	Worse	No change	_____
Laying down	Better	Worse	No change	_____
Lifting	Better	Worse	No change	_____
Bending forward	Better	Worse	No change	_____
Bending backward	Better	Worse	No change	_____
Twisting	Better	Worse	No change	_____
Driving	Better	Worse	No change	_____
Coughing/sneezing	Better	Worse	No change	_____
Straining at stool	Better	Worse	No change	_____

7. Is there anything else that makes you better?

☐ No

☐ Yes, Describe_____

_____

8. Is there anything that makes you worse?

☐ No

☐ Yes, Describe_____

_____

9. Do your symptoms ever go away completely?

☐ No

☐ Yes, What shuts them off? _____

_____

10. Do your symptoms interfere with your sleep?

☐ No

☐ Yes, Describe_____

_____

_____

11. Have you had problems with the following?

Y	N	
☐	☐	Weakness
☐	☐	Unsteady gait
☐	☐	Clumbsiness
☐	☐	Loss of bladder control
☐	☐	Loss of bowel control

Describe any positives _____

_____

12. Do you need assistance with any of the following?

Y	N		Y	N	
☐	☐	Toileting	☐	☐	Getting out of bed
☐	☐	Dressing	☐	☐	Walking
☐	☐	Feeding			

13. Do you use any of the following?

Y	N		Y	N	
☐	☐	Walker	☐	☐	Wheelchair
☐	☐	Crutch	☐	☐	Special bed
☐	☐	Cane	☐	☐	Commode

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1. Pain can be influenced by many different bodily functions. Have you had any of the following?

Y	N		Y	N	
☐	☐	High cholesterol	☐	☐	Abdominal pain
☐	☐	Thyroid problems	☐	☐	Nausea or vomiting
☐	☐	Epilepsy/seizures	☐	☐	Constipation
☐	☐	Parkinsons	☐	☐	Diarrhea
☐	☐	Memory/concentration loss	☐	☐	Black or bloody stools
☐	☐	Tremors	☐	☐	Blood disorders
☐	☐	Dizzy spells	☐	☐	Anemia
☐	☐	Fainting or blackouts	☐	☐	Easy bruising or bleeding
☐	☐	Change in appetite	☐	☐	Swollen lymph glands
☐	☐	Recent weight changes	☐	☐	Chest pain
☐	☐	Fevers, chills, or night sweats	☐	☐	Palpitations
☐	☐	Rashes	☐	☐	Swelling of feet/ankles
☐	☐	Eye irritation	☐	☐	Difficulty breathing
☐	☐	Blurred or double vision	☐	☐	Chronic cough
☐	☐	Glaucoma	☐	☐	Environmental allergies
☐	☐	Ringing in ears	☐	☐	Food allergies
☐	☐	Hearing loss	☐	☐	TB
☐	☐	Prostate problems	☐	☐	Non healing wounds
☐	☐	Burning with urination	☐	☐	Changes in hair or nails
☐	☐	Excess thirst or urination	☐	☐	Sore throat