east greenwich
spine & sport

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Baseline Questionnaire

Please complete this questionnaire **before** you come for your appointment.
Be sure to call us as soon as possible if you cannot make your appointment. Thank you.

Name _____ Date _____

Age _____ Sex _____ Marital Status_____ Date of Birth ___/_____/_____ Height _____ Weight _____
(month / day / year)

Primary Physician's Name & Address _____

_____

Referring Physician's Name & Address (if different) _____

_____

Questions About Your Current Problem

1. When did you first start having problems? _____/_____/_____
(month / day / year)

2. Please check all that apply:
   - ❑ This is my first episode of pain.
   - ❑ I have had more than one episode of pain.
   - ❑ In between episodes I don't have much pain.
   - ❑ I have had pain continuously ever since it first began. Sometimes it is worse than others, but it is always there.
   - ❑ I have had constant, severe pain ever since it first began.

3. Are your symptoms related to an injury (including repetitive strain injuries)?
   - ❑ NO (GO TO QUESTION 4)
   - ❑ YES, answer the following:

   a. Date of injury _____/_____/_____
   (month / day / year)

   b. The injury was a *(Choose one)*:
      - ❑ Motor Vehicle Injury
      - ❑ Lifting Injury
      - ❑ Falling Injury
      - ❑ Repetative Strain
      - ❑ Following Illness
      - ❑ Pain just began-cannot relate it to anything
      - ❑ Other_____

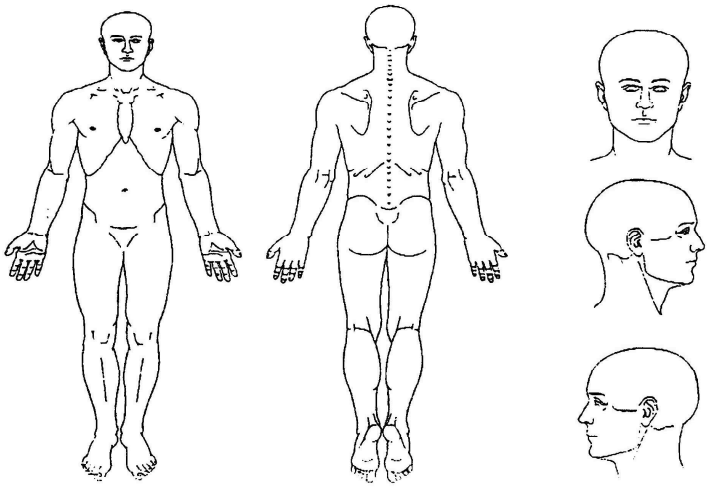
   c. The injury was *(choose one)*:
      - ❑ Work related
      - ❑ Not work related

   d. Please describe your injury in as much detail as possible: _____

_____

_____

4. On the diagram below, **shade** the areas where you feel pain. **Mark an "X"** over the area(s) with the worst pain.



Circle the words that describe your pain:	
Aching	Shooting
Sharp	Stabbing
Penetrating	Intermittent
Continuous	Gnawing
Tiring	Burning
Tender	Throbbing
Nagging	Exhausting
Tingling	Numb
Miserable	Unbearable

Are your symptoms:

- ❑ Always there
- ❑ On and off

Have your symptoms been:

- ❑ Improving
- ❑ Relatively stable
- ❑ Worsening

Which hurts you more, your limbs or your spine?

- ❑ Arms/legs hurt much more
- ❑ Arms/legs hurt somewhat more
- ❑ Arms/legs and neck/back hurt about the same
- ❑ Neck/back hurts somewhat more
- ❑ Neck/back hurts much more

If you have both limb and spine pain:
My limbs are _____% of my pain
My spine is _____% of my pain

Total should be 100%

5. Note the effect of the following activities on your symptoms. *Check one box on each line:*

Activity	Better	Worse	No Change
Bending			
Sitting			
Sitting at computer/desk			
Driving			
Standing			
Walking			
Lying down			
Coughing or Straining			
Reading			

I can sit_____minutes
before needing to move

- ❑ No limit sitting

I can walk

- ❑ < a block
- ❑ 1 block---5 blocks
- ❑ ¼ mile---mile

before needing to rest.

- ❑ No limit walking

Circle the number that best describes your pain at its **worst** in the past month:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Circle the number that best describes your pain at its **least** in the past month:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Circle the number that best describes your pain **right now:**

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

6. What treatments have you tried **for your pain**?

- ❑ Opioid pills (eg. Tylenol w/ Codeine, Vicoden etc.)
- ❑ Antidepressants (Elavil, Prozac, etc.)
- ❑ Anti-seizure medications (Neurontin)
- ❑ Muscle relaxants (Flexeril, etc.)
- ❑ Anti-anxiety medications (Valium, Xanax, etc.)
- ❑ Anti-inflammatories (Motrin, Aleve, Celebrex, etc.)
- ❑ Physical Therapy # visits____
- ❑ Last visit ____/____ month / year
- ❑ Chiropractic/Osteopathic manipulation
- ❑ Acupuncture
- ❑ Psychological/Psychiatric Counseling
- ❑ Other_____

7. Have you had surgery or injections **related to your pain?**

Procedure Number	Date	Procedure Type (Please provide details)	Change in condition after procedure (circle one, indicate duration of effect)
1			Same Better Worse For _____ (length of time)
2			Same Better Worse For _____
3			Same Better Worse For _____

8. Have any of the following **tests** been done **related to your pain?**

Test	*When?*	*What hospital / clinic?*	*Findings*
❑ MRI			
❑ CT (CAT Scan)			
❑ Xray			
❑ EMG			
❑ Discogram			
❑ Bone scan			
❑ Myelogram			
❑ Other tests:			

9. Please list all the medications you **currently** take for **any reason** (including non-prescription drugs).

Drug Name	*Dose*	*How Often?*	*Pain meds only - Does it help?*
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

10. Please list all known drug allergies: _____

11. Have you had any of the following since your current symptoms started? *(check all that apply)*

- ❑ Episodes of sadness or depression
- ❑ Anxiety
- ❑ Crying spells
- ❑ Difficulty sleeping
- ❑ Eye irritation
- ❑ Fever or chills
- ❑ Unexplained weight loss/gain
- ❑ Swollen joints
- ❑ Skin disease

12. **Past Medical History / Review of Systems:** Please check one for each question:

□ yes □ no Heart problem? If yes, describe: _____
□ yes □ no Palpitations?
□ yes □ no High blood pressure?
□ yes □ no Aortic aneurysm?
□ yes □ no Chest pain when you work hard?
□ yes □ no Taking heart medications?
□ yes □ no High cholesterol? Level if known _____
□ yes □ no Circulatory problems?
□ yes □ no History of respiratory disorders?(Asthma, Emphysema)
□ yes □ no Difficulty with coughing or sneezing?
□ yes □ no Do you get short of breath easily?
□ yes □ no Intestinal disorder?
□ yes □ no Blood in your bowel movements?
□ yes □ no Gastrointestinal reflux? (GERD)
□ yes □ no Heartburn
□ yes □ no Skin rash?
□ yes □ no Excessively dry eyes?
□ yes □ no Frequent sores in your mouth?
□ yes □ no Arthritis? What type? Which joints? _____
□ yes □ no Gout?
□ yes □ no Hypothyroid or thyroid problem?
□ yes □ no Are you diabetic? If yes, are you insulin dependent? □yes □ no
□ yes □ no Tumors or Cancer? If yes, what type? _____
□ yes □ no Kidney stones?
□ yes □ no Any blood in your urine?

□ yes □ no Urinary tract infection?
□ yes □ no Are you running a fever?
□ yes □ no Tooth abscess or any other infection in the last year?
□ yes □ no AIDS or HIV positive?
□ yes □ no Hepatitis, liver disease?
□ yes □ no Treated for a psychiatric disorder? Type: _____
□ yes □ no History of serious injury?
□ yes □ no Do you have a history of stroke?
□ yes □ no Weakness? Which body parts? _____
□ yes □ no Disease of the nerves or muscles? If so, what? _____
□ yes □ no Changes in urinating or bowel movement patterns?
□ yes □ no Loss of control of bowels or bladder?
□ yes □ no (Men only) Difficulty with erections?
□ yes □ no Head injury with loss of consciousness?
□ yes □ no Epilepsy?
□ yes □ no Frequent headaches?
□ yes □ no Visual changes?
□ yes □ no Difficulty with loud noises?
□ yes □ no Ear pain or difficulty hearing?
□ yes □ no Difficulty chewing and swallowing?
□ yes □ no Pain in your jaw?
□ yes □ no Any injuries to other bones or joints? Which? _____
□ yes □ no Any pain in other joints? Which? _____

□ yes □ no Do you have any other health problems not mentioned above? If yes, please explain:

_____

_____

□ yes □ no Have you ever been hospitalized or had surgery? If yes, please list:

_____

_____

13. **Family History:** (*check all that apply)*

- ❑ Family history of disabling back or neck pain
- ❑ Family history of disability from work for other reasons
- ❑ Arthritis: (*type*? _____)
- ❑ Muscle or nerve disease: _____

Office use only:

Phys/NP_____ Date _____

14. **Social History:**

With whom do you live and what is their relationship to you?_____

Are there any substance abuse issues in the household? Yes_____ No_____
If Yes, please explain_____

Do you need/have assistance with self care or household activities? Yes_____ No_____
If Yes, please explain_____

Do you smoke? Yes___No__ Did you ever? Yes____ No____ When did you quit?____ Packs/day____ # years____

How many cups of coffee, tea or cola do you drink each day? _____

Do you use alcohol regularly? Yes ___ No ___ If yes, do you use it ("**O**") occasionally/once a month, ("**F**") frequently/once a week, or ("**C**") continuously/every day.

What have you been doing for exercise? _____Minutes_____Sessions/Wk_____

What is your occupation?_____

Are you <u>currently</u> working?

- ❑ YES (choose the **one** answer that best describes your current work situation)
  - ☐ I have the exact same job since I started having symptoms
  - ☐ I have the same job, but it was modified or the hours were reduced because of my symptoms
  - ☐ I have changed jobs because of my symptoms
  - ☐ I have changed jobs, but for reasons unrelated to my symptoms

- ❑ NO (*please answer the following)*
  - ☐ I choose not to work
  - ☐ I have been off work for _____ year(s) _____ month(s) _____ week(s)
  - ☐ Check which of the following describes your current work status (*please check one)*
    - ☐ I am unable to work because of my symptoms
    - ☐ I am able to work but I am unemployed

- ❑ Which of the following best describes your plans for future employment? (*please check one)*
  - ☐ I intend to return to my same job
  - ☐ I plan to return to my occupation but with restricted duty
  - ☐ I plan to find a different occupation
  - ☐ I don't intend to return to work

If you are on modified duty, please list the physician (and phone #) ordering the restrictions: _____, the start date _____ and the expiration date _____of the restrictions.

15. **ADVANCED DIRECTIVES**

Do you have a Durable Power of Attorney or a living will? Yes___ No___

16. **PRIVACY**

HIPPA regulations require our practice to ask your permission to share your medical information with people other than your insurance and other physicians involved in your care (e.g. spouses, children or friends and family). Please list anyone you would like us to share/discuss your healthcare information with and their relationship to you:

_____

_____