Oregon Spine Care

New Patient Questionnaire

Name:____ Birth Date:_________________________________

Current Height: ____________________________ Weight: ______________________________________

Chief Complaint: ____

When did your spine problem first begin? ____

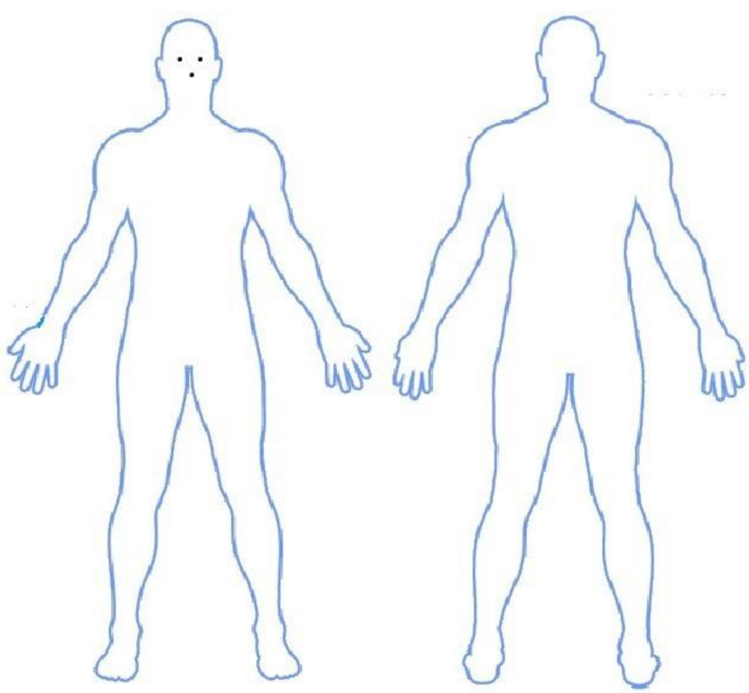
Did your pain start because of an: Accident at work Motor vehicle accident

If there was an accident, what caused the pain .____

Workers Compensation Claim? [ ] Yes [ ] No

Do you have any problems controlling your bowel and / or bladder? [ ] Yes [ ] No
Hand dominance: Right Left
Mark the areas of your body where you feel pain, numbness or weakness. Use the appropriate symbol.

Numbness or pins/needles	O O O O O O O O O O O
Aching or cramping	X X X X X X X X X X X X X
Muscle weakness	+ + + + + + + + + + + + + +



Right Left Left Right

NEW NECK PAIN: ***Circle*** *all those that apply*

Chief Complaint: *Neck Headache Right Shoulder Left Shoulder Right Upper Extremity Left Upper Extremity*
Overall Neck Pain: *1…2…3…4…5…6…7…8…9…10* ***Overall Upper Extremity Pain:*** *1…2…3…4…5…6…7…8…9…10*
Neck pain: choose most applicable:
Neck pain > Upper extremity pain Upper extremity pain > neck pain Upper extremity pain = neck pain

NECK PAIN	ARM PAIN QUALITY	NUMBNESS	WEAKNESS
Aching	Aching	None	None
Burning	Burning	Right Shoulder	Right Shoulder
Stabbing	Stabbing	Right Arm	Right Arm
Throbbing	Throbbing	Right Forearm	Right Forearm
Tingling	Tingling	Right Thumb	Right Thumb
		Right Long Finger	Right Long Finger
Constant	Constant	Right Small Finger	Right Small Finger
Intermittent	Intermittent		
		Left Shoulder	Left Shoulder
		Left Arm	Left Arm
Gradually Worsening	Gradually Worsening	Left Forearm	Left Forearm
Rapidly Worsening	Rapidly Worsening	Left Thumb	Left Thumb
Gradually Improving	Gradually Improving	Left Long Finger	Left Long Finger
Rapidly Improving	Rapidly Improving	Left Small Finger	Left Small Finger

NEW BACK PAIN: ***Circle*** *all those that apply*

Chief Complaint: *Mid-Back Low Back Sacrum Right Buttock Left Buttock Right Lower Extremity Left Lower Extremity*
Overall Back Pain: *1…2…3…4…5…6…7…8…9…10* ***Overall Lower Extremity Pain:*** *1…2…3…4…5…6…7…8…9…10*
Back pain: choose most applicable:
Back pain > lower extremity pain Lower extremity pain > back pain Lower extremity pain = back pain

BACK PAIN QUALITY	LEG PAIN QUALITY	NUMBNESS	WEAKNESS
Aching	Aching	Left Buttock	Left Buttock
Burning	Burning	Left Anterior Thigh	Left Hip
Stabbing	Stabbing	Left Knee	Left Thigh
Throbbing	Throbbing	Left Shin	Left Ankle
Tingling	Tingling	Left Top of Foot	Left Big Toe
		Left Bottom of Foot	Left Calf
Constant	Constant		
Intermittent	Intermittent	Right Buttock	Right Buttock
		Right Anterior Thigh	Right Hip
Gradually Worsening	Gradually Worsening	Right Knee	Right Thigh
Rapidly Worsening	Rapidly Worsening	Right Shin	Right Ankle
Gradually Improving	Gradually Improving	Right Top of Foot	Right Big Toe
Rapidly Improving	Rapidly Improving	Right Bottom of Foot	Right Calf

The symptoms are better with: Rest Lying down Bending forward Bending backward
The symptoms are worse with Bending forward Bending backward Sitting Standing/Walking

Treatments

Physical Therapy [ ] never tried [ ] helpful [ ] not helpful
Last treatment _____________ Where_______________ Dates______________

What treatment was performed? [ ] exercises [ ] stretching [ ] TENS unit [ ] ultrasound [ ]massage

Spine Injections [ ] never tried [ ] helpful [ ] not helpful

Last treatment _____________ Where_______________ Dates______________

Acupuncture [ ] never tried [ ] helpful [ ] not helpful
Last treatment _____________ Where_______________ Dates______________

Chiropractics [ ] never tried [ ] helpful [ ] not helpful
Last treatment _____________ Where_______________ Dates______________

Oral Steroids [ ] never tried [ ] helpful [ ] not helpful
Last treatment _____________ Where_______________ Dates______________

REVIEW OF SYSTEMS

Are you having any of these symptoms/conditions **today**

Constitutional/General
Fever [ ] Yes [ ] No
Chills [ ] Yes [ ] No

Ears/Nose/Mouth/Throat
Dizziness [ ] Yes [ ] No
Difficulty Swallowing [ ] Yes [ ] No

Endocrine
Diabetes [ ] Yes [ ] No
Fatigue [ ] Yes [ ] No

Gastrointestinal
Ulcers [ ] Yes [ ] No
GERD [ ] Yes [ ] No

Hematologic/Lymphatic
Anemia [ ] Yes [ ] No
Bleeding Problem [ ] Yes [ ] No

Neurologic
Headache [ ] Yes [ ] No
Seizures [ ] Yes [ ] No

Cardiovascular
Chest Pain [ ] Yes [ ] No
Irregular Heart beat [ ] Yes [ ] No

Psychiatric
Depression [ ] Yes [ ] No
Anxiety [ ] Yes [ ] No

Genitourinary
Urgent urination [ ] Yes [ ] No
Frequent urination [ ] Yes [ ] No

Pulmonary
Shortness of Breath [ ] Yes [ ] No
Asthma [ ] Yes [ ] No

Please list any spine surgeries [ ] NONE

Lumbar	Type of Surgery	Date	Surgeon	Helpful	SX
1				Yes No	
2				Yes No	

Cervical	Type of Surgery	Date	Surgeon	Helpful	SX
1				Yes No	
2				Yes No	

Medications – Attach sheet if necessary [ ] Check if No Medications

Medication	***Strength/Directions***

Allergies– Attach sheet if necessary [ ] Check if No known drug allergies

Medication/Allergies	**Reaction**

MEDICAL HISTORY
Please check the box if you have any of the following conditions:

[] Anxiety	[] Arthritis	[] Asthma	[] Blood Disorder
[] Cancer	[] Depression	[] Diabetes	[] Epilepsy
[] Heart Disease	[] High Blood Pressure	[] High Cholesterol	[] Kidney Disease
[] Multiple Sclerosis	[] Osteoporosis	[] Seizures	[] Stroke

FAMILY HISTORY

Please check the box if anyone in your immediate family has had any of the following conditions:
(NOTE RELATIONSHIP PLEASE Specify maternal/paternal for grandparents ie: maternal grandfather)

[] Anxiety ____________	[] Arthritis ____________	[] Asthma____________
[] Blood Disorder ____________	[] Cancer ____________	[] Depression ____________
[] Diabetes ____________	[] Epilepsy ____________	[] Heart Disease ____________
[] High Blood Pressure ____________	[] High Cholesterol ___________	[]Kidney Disease ____________
[] Multiple Sclerosis ____________	[] Osteoporosis ____________	[] Seizures ____________

SOCIAL HISTORY

Current Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ]Partner

Living Status: [ ] alone [ ] with spouse [ ] with parents [ ] with roommate [ ] assisted living [ ] nursing home

Current Occupation:______________________________

Highest education level: [ ] Grade School [ ] Middle School [ ] High School [ ] College [ ] Post Graduate

Do you use tobacco now or in the past? [ ] Yes, use now [ ] Never used [ ] Previous user
Cigarettes How many per day? _________ How many years? ___________
Cigars How many per day? _________ How many years? ___________

Do you drink alcoholic beverages? [ ] Never [ ] Weekly [ ] 1-2 x week [ ] 3 x week

Have you ever felt the need to cut down on drinking? [ ] Yes [ ] No
Have you ever felt annoyed by criticism of your drinking? [ ] Yes [ ] No
Have you ever felt guilty about your drinking? [ ] Yes [ ] No
Have you ever felt the need for a morning eye-opener? [ ] Yes [ ] No

Have you tried illicit drugs? [ ] Yes, use now [ ] Never used [ ] Previous user What was the substance?_________________________

Please check / list all operations: [ ] none

[ ] Appendectomy When:________________________
[ ] Tonsillectomy When:________________________
[ ] Gall bladder removal When:________________________
[ ] Knee arthroscopy When:________________________
[ ] Knee replacement When:________________________
[ ] Hip replacement When:________________________
[ ] ________________ When:________________________
[ ] Eye Surgery When:________________________
[ ] Heart surgery When:________________________
[ ] Hysterectomy When:________________________
[ ] Prostate surgery When:________________________
[ ] Surgery for cancer When:________________________
[ ] ________________ When:________________________
[ ] ________________ When:________________________