COMPREHENSIVE SPINE QUESTIONNAIRE

Name:_____ Date of Birth: _____ Sex: □ Male □ Female

Health care number:_____ Your weight_____ Your height_____

Since the onset of pain have you noticed any of the following symptoms?

Numbness/weakness

□ Arm (L) (R) □ Hand (L) (R)

□ Leg (L) (R) □ Feet (L) (R)

□ Clumsiness of hands: (L) (R)

□ Balance problems

□ Bladder problems

□ Bowel problems

□ Pain that awakens you from a sleep

Is the pain?

□ Mild □ Dull pain worse at times

□ Hard aching pain, frequently worse

□ Severe pain

□ Sharp □ Shooting □ Disabling

How often do you have the pain?

□ Occasional (1-2 times/year)

□ Recurrent (2-3 days/month)

□ Frequent (> 3 days/month)

□ Very Frequent (every week)

□ Every day

What make the pain worse?

□ Lying down □ Looking down/up

□ Sitting □ Looking left/right

□ Standing □ Bending forward

□ Walking □ Bending backward

□ Twisting □ Sneeze/Cough

Your condition is getting

□ Slowly Better □ Slowly Worse

□ Rapidly Better □ Rapidly Worse

□ Unchanged

What other medical doctors have you seen for your spine?

_____

_____

What tests have been done?

□ X-ray □ MRI □ CT Scan □ Bone Scan □ EMG

What treatment have you received?

□ None □ Medication

□ Chiropractic □ Physiotherapy

□ Traction □ Spinal Block

□ Hospitalized □ Other_____

What caused your symptoms?

□ Work injury □ Motor vehicle accident

□ Unknown □ Other_____

Have you filed work injury claims or motor vehicle accidents in the past?

□ No

□ Yes; Please list dates and what was injured

_____

_____

Have you had spine surgery?

□ No

□ Yes; List type, approximate date

_____

Please list your medications and dosages:

_____

_____

Allergies to medications:

□ No

□ Yes; list drug and reaction

_____

Do you smoke?

□ No

□ Yes: How much/often?

Medical History

□ Fever or Chills	□ Bleeding disorder
□ Weight loss	□ Cancer
□ Productive cough	□ Hepatitis
□ Lung disease	□ HIV
□ Shortness of breath	□ Muscle weakness
□ Heart disease	□ Ankle/leg swelling
□ Chest pain	□ Depression
□ Diabetes	□ Other_____

Spinal Deformity

□ Scoliosis □ Kyphosis

Cobb's angle_____ degree

Please indicate that you have completed this form truthfully and as accurately as possible by signing below,

Signature:_____Date:_____

For Doctors:

PRAC ID#_____

Name: _____

Fax #: _____

Specific Requests:_____

_____

Signature:_____Date:_____

PAIN SCALE:

How much of your pain is in your neck/back and how much is in your arm/leg?

_____% neck/back + _____% arm/leg = 100%

Rate your pain at its worst and at its best.

0 = No pain 10 = worst pain imaginable

0 2 4 6 8 10

Worst

0 2 4 6 8 10

Best

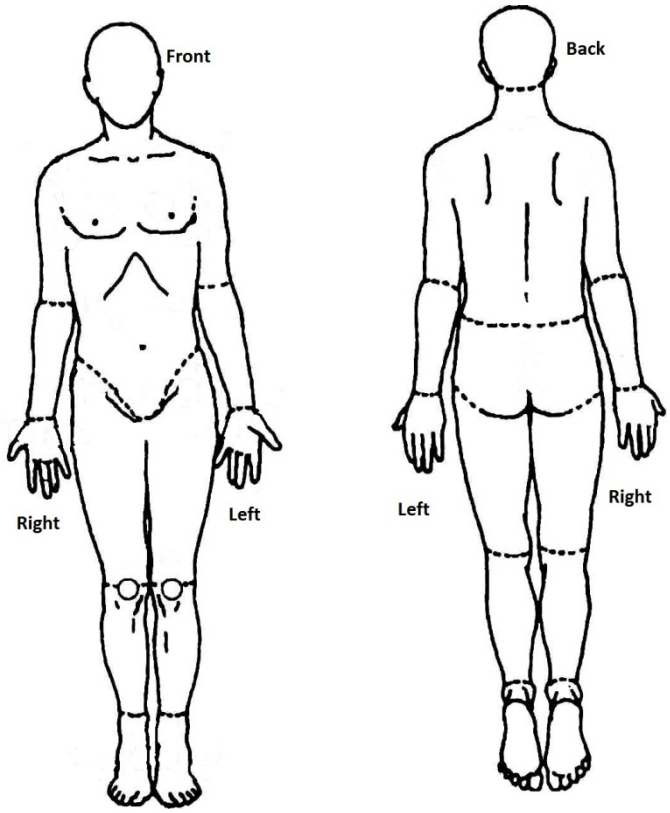
PAIN DRAWING

Indicate where you are having pain by using the following symbols

Aching pain (XXX) Numbness/tingling (OOO)

Pins/needles (:::::) Burning (////)

Spasm/cramp (>>>)



***Please Include Imaging Documents