SPINE QUESTIONNAIRE

Patient name: ______________________________ Date of Birth: ___________ Today's Date: ______________

Body Part being evaluated today: ☐ Neck ☐ Mid back ☐ Low back Date of Injury: ______________________

Is this problem related to an injury? ☐ yes ☐ no Work related injury? ☐ yes ☐ no Motor vehicle accident ☐ yes ☐ no

Give a brief history of pain/injury: ____

____

____

How did your symptoms start? ☐ Suddenly ☐ Gradually

How long have is your symptoms been occurring? ____ Hours ____ Days ____ Weeks ____ Months ____ Years

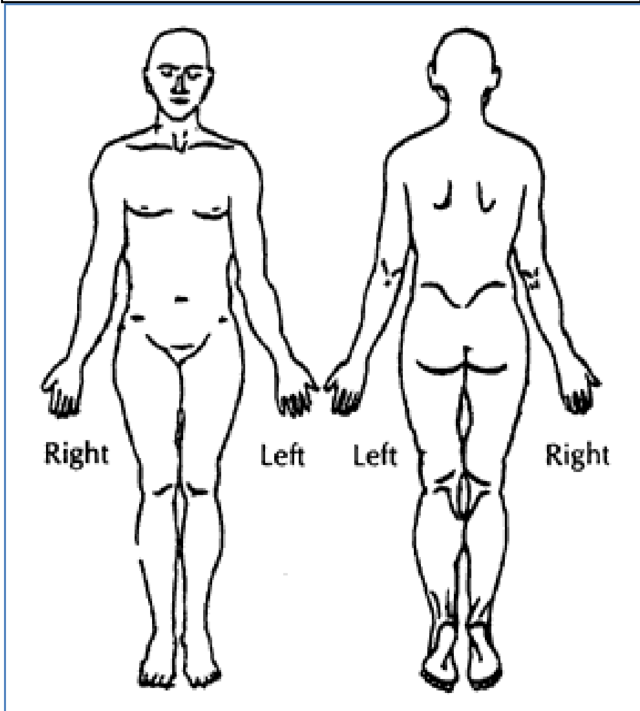
Pattern of pain: ☐ constant ☐ intermittent ☐ comes and goes ☐ constant with intermittent flares

The symptoms are: ☐ improving ☐ worsening ☐ recurring ☐ not changing

Rate your pain on a scale of 0/10 (please circle) 0 1 2 3 4 5 6 7 8 9 10

PAIN CHART

Please Mark the areas you have pain with an "X"
Please Mark the areas of numbness or tingling with an "O"



How would you best describe your pain?

☐ sharp ☐ achy ☐ dull
☐ stabbing ☐ sore ☐ burning
☐ shooting ☐ throbbing ☐____________

Does your pain radiate? ☐ yes ☐ no

If yes, to where?

☐ head ☐ shoulder blade ☐ upper back
☐ right arm ☐ left arm ☐ abdomen
☐ buttocks ☐ right leg ☐ left leg
☐ other ______________________________

Do you have headaches? ☐ yes ☐ no

Do you have stiffness? ☐ yes ☐ no

Do you have any of the following symptoms?

☐ arm weakness ☐ leg weakness
☐ numbness of arms ☐ numbness of legs
☐ numbness of buttocks ☐ numbness of genitals
☐ poor balance ☐ gait abnormality
☐ incontinence of urine ☐ incontinence of stool
☐ unable to urinate

Your symptoms are aggravated by: ☐ nothing ☐ sitting ☐ standing ☐ walking ☐ bending forward ☐ twisting
☐ coughing ☐ sneezing ☐ sports ☐ work ☐ weather changes ☐ other: __________________________

Do you have difficulty with: ☐ writing ☐ gripping/grasping ☐ walking ☐ standing from a seated position
☐ getting in and out of a car ☐ putting on shoes and socks ☐ Other: ______________________________
A

Your pain is relieved by: ☐ nothing ☐ rest ☐ lying down ☐ posture correction
☐ activity modification ☐ sitting ☐ standing ☐ walking ☐ bending forward
☐ ice ☐ heat ☐ medication ☐ squatting ☐ Other: ______________________________________

PLEASE TURN OVER AND FILL OUT PAGE 2

Patient name: ________________________ **Today's Date:** __________

What assistive devices do you use? □ Brace □ Cane □ Walker □ Wheelchair

What treatment have you had **FOR THIS CONDITION** in the past year:

□ physical therapy For how long? ____ weeks _____ months Did it help? □ yes □ no
□ chiropractic treatment For how long? ____ weeks _____ months Did it help? □ yes □ no
□ osteopathic treatment □ massage □ exercise □ trigger point injections □ acupuncture
□ facet injections □ epidural injections □ selective nerve block □ SI joint infections
□ rhizotomy / radiofrequency ablation Other: ________________________

What medications do you take **FOR THIS CONDITION**? ________________________

What tests have you had **FOR THIS CONDITION**? □ X-ray □ MRI □ CT □ CT myelogram □ EMG
□ Other: ________________________
Where were tests taken: ________________________

Have you had surgery on your spine? Describe: ________________________

REVIEW OF SYSTEMS – **check all that apply**

General	**cardiovascular**	**gastrointestinal**	**genitourinary**	**neurological**
□ fever	□ chest pain	□ constipation	□ incontinence	□ dizziness
□ chills	□ palpitations	□ nausea	□ painful urination	□ numbness/Tingling
		□ Heartburn	□	
difficulty urinating	□ tingling			
				□ headaches

Respiratory	**Skin**	**hematology**	**psychiatric**	**musculoskeletal**
□ cough	□ bruising	□ nosebleeds	□ anxious	□ joint pain
□ wheezing	□ rash	□ calf pain	□ depressed	□ joint swelling
□ difficulty breathing				

FOR OFFICE USE

Inspection: ________________________

Tenderness: ________________________

Sensation: ________________________

Abd (R) /5 Elb Flex (R) /5 Elb Ext (R) /5 Wrist Ext (R) /5 Fing Ext (R) /5 Grip (R) /5 Intriniscs (R) /5
Abd (L) /5 Elb Flex (L) /5 Elb Ext (L) /5 Wrist Ext (L) /5 Fing Ext (L) /5 Grip (L) /5 Intriniscs (L) /5

Hip Flex (R) /5 Hip Abd (R) /5 Leg Ext (R) /5 Leg Flex (R) /5 DF (R) /5 PF (R) /5 GTE (R) /5
Hip Flex (L) /5 Hip Abd (L) /5 Leg Ext (L) /5 Leg Flex (L) /5 DF (L) /5 PF (L) /5 GTE (L) /5

Reflexes Bic (R) /4 Tric (R) /4 Brach (R) /4 Knee (R) /4 Ach () /4
Bic (L) /4 Tric (L) /4 Brach (L) /4 Knee (L) /4 Ach (L) /4

Functional Tests + - Hoffmanns (R) + - Spurlings (R) + - Clonus (R) + - SLR (R)
+ - Hoffmanns (L) + - Spurlings (L) + - Clonus (L) + - SLR (L)
+ - Rhombergs