Orthopaedic Specialists of North Carolina

Back and Neck Pain Questionnaire

Please print legibly in black ink. Answer only questions applicable to your condition. Leave other spaces blank.

Date you are filling out this form:

PERSONAL DATA

Name: **Medical Record #:**

Referring Physician: Age: ☐ Male ☐ Female

Height: Weight: E-mail address: _____

What is your primary problem? _____

How did it begin (check all that apply): ☐ Gradually ☐ Suddenly ☐ Wokeup with it

☐ Fall: (how high ft) ☐ Twisting ☐ Bending ☐ Running ☐ Pushing

☐ Lifting: (how much lbs) ☐ Pulling ☐ Reaching ☐ Direct blow

☐ Motor Vehicle Accident ☐ Other:

Was this the result of an injury at: ☐ Work ☐ School ☐ Sports ☐ Unrelated

Is there/will there be legal action? ☐ No ☐ Yes What is the current status of this action?

Is there a Workers' Compensation claim pending/active? ☐ No ☐ Yes

Have you or will you hire a personal attorney? ☐ No ☐ Yes ☐ Undecided

Did you ever have to be hospitalized for your back/neck pain (other than for surgery)? ☐ No ☐ Yes

Have you had spinal surgery? ☐ No ☐ Yes If yes, please describe below:

How many spine surgeries have you had?

Please list all spine surgeries:

Date Surgeon Location Type of procedure:

Date Surgeon Location Type of procedure:

Over the last year, have you tried ***physical therapy***? ☐ No ☐ Yes What did the therapy include (please list)?

Overall, did you find therapy helpful? ☐ No ☐ Yes

Have you tried ***lumbar epidural steroid injections***? ☐ No ☐ Yes

If yes, ***how many*** have been done over the last year? When was the last injection?

Overall, do you find the epidural steroid injections helpful? ☐ No ☐ Yes

If they are helpful to you, how long does the benefit last? Days Weeks Months

Over the last year, what ***pain medications*** have you tried, but are ***no longer taking***?

What ***pain medications*** are you ***currently taking***? Name/Dose/How many per day?

LIMITATIONS

Despite the treatments tried and medications being used, are you still limited by your back and/or leg pain?

☐ No ☐ Yes

What ***recreational*** activities would you like to do, but can't specifically because of your back and/or leg pain?

What ***social*** activities have you given up because of the pain?

Does walking bring on, or make worse, the pain in your ☐ legs ☐ low back?

How far can you ***comfortably walk***? blocks

Which condition best describes the percentage of pain in your back vs. in your legs:

☐ 100% back / 0% legs ☐ 75% back / 25% legs ☐ 50% back / 50% legs

☐ 25% back / 75% legs ☐ 0% back / 100 % legs

Please further define your ***leg pain*** : (for total of 100%)

My leg pain is % Right-sided My leg pain is % Left-sided

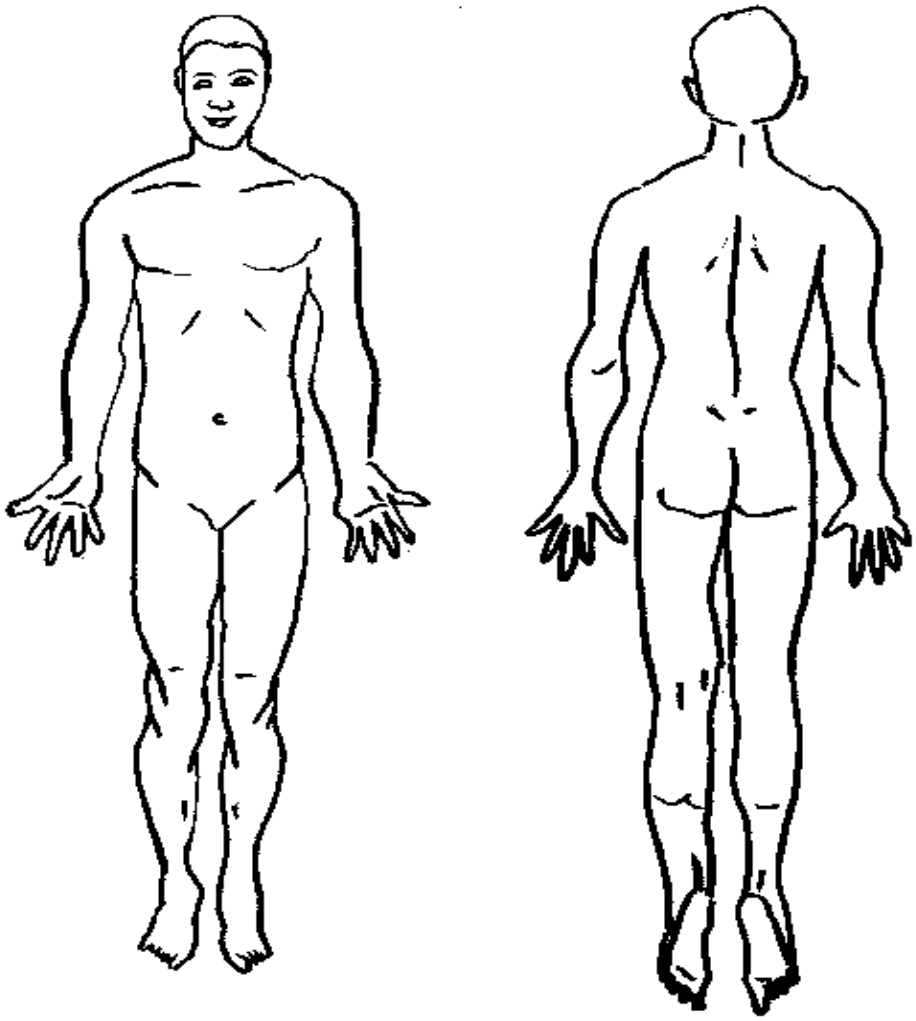
Which of the following make your pain ***worst***? (check one)

☐ walking ☐ standing ☐ sitting ☐ lying down

What do you do to ***relieve*** the pain? ☐ sitting ☐ leaning forward ☐ lying down ☐ other (please explain)

PAIN DIAGRAM

Please note the orientation of the diagrams below and mark on them the exact spots where you are experiencing any of the following sensations on your own body (please use only the symbols listed):



= = = = **Numbness**

O O O O **Pins and Needles**

X X X X **Burning**

> > > > **Aching**

/ / / / **Stabbing**

● ● ● ● **Other**

(explain)

_____

Place a vertical mark on the line below to indicate how bad your pain is

No Pain l----------l Very Severe Pain

ASSOCIATED SYMPTOMS

Before we move on to describe the history of your pain, we have some questions directed at helping us to know whether your spinal nerves are being compressed and affecting other basic functions.

Do you have problems controlling your ***urination***? ☐ No ☐ Yes If yes, please describe your difficulties:

Do you have problems controlling your ***bowel movements***? ☐ No ☐ Yes If yes, please describe your difficulties:

Do you have ***numbness*** in the following areas? (check all that apply)

☐ Buttocks ☐ Perianal ☐ Back of upper thigh ☐ Vaginal ☐ Penile ☐ Scrotal

Does your pain/difficulty ***impair*** your ability to have sexual intercourse? ☐ No ☐ Yes

How is your ***appetite***? ☐ Good ☐ Bad

Do you regularly get ***fevers***? ☐ No ☐ Yes; ***Chills***? ☐ No ☐ Yes; N***ight sweats***? ☐ No ☐ Yes

Circle a number below on each line to indicate any problems you are experiencing with:

	None									Severe
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10
Poor sleep	1	2	3	4	5	6	7	8	9	10
Irritibility	1	2	3	4	5	6	7	8	9	10

WORK HISTORY AND LIMITATIONS

Are you currently working? ☐ No ☐ Yes If yes, how many days per month do you miss from work because of your pain: days If no, did you stop working because of your pain? ☐ No ☐ Yes

Current/Recent Employer: Date of Hire: Usual occupation:

Briefly describe your job:

Do/did you like your job? ☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Hate it

Physical demands of your job:

☐ Very heavy (frequently lift >100 lbs) ☐ Light (frequently lift 15-30 lbs)

☐ Heavy (frequently lift >60 lbs) ☐ I use my hands to do repetitive motion type tasks

☐ Moderate (frequently lift >30 lbs) ☐ Sedentary (no lifting or repetitive motion tasks)

Work status ***today***:

☐ Regular duties ☐ On disability (date begun)

☐ Light or modified duties (date begun) ☐ On time loss (date begun)

What are your limitations at work? Cite specific duties or activities with which you have difficulty.

PAST MEDICAL HISTORY

Who is your primary care provider and where are they located?

When were you last seen for a general physical? Date

Do you have (or have you had) any of the following? (please check all that apply)

☐ myocardial infarction (heart attack) If so, what year?

☐ stroke

☐ pulmonary embolus

☐ coronary artery disease

☐ high blood pressure

☐ peripheral vascular disease (poor circulation of legs)

☐ asthma

☐ pneumonia, what year

☐ other lung problems, describe

☐ Others (please list):

☐ stomach ulcers/ gastritis

☐ hepatitis if so, what year

☐ kidney disease

☐ rheumatoid arthritis

☐ lupus

☐ HIV

☐ cancer

☐ Diabetes

PAST SURGICAL HISTORY

You've already listed spinal surgeries. Please list other surgeries (Procedures/Date)

During any of your surgeries including spine surgery:

Were there any major complications with anesthesia? ☐ No ☐ Yes

Were there any major bleeding or clotting complications? ☐ No ☐ Yes If yes, please describe:

Do you have a tendency to bleed easily? ☐ No ☐ Yes Do you bruise easily? ☐ No ☐ Yes

CURRENT MEDICATIONS

Please list ***all*** of your current medications (pain medications first): Medication/Dose/Frequency

MEDICATION ALLERGIES

Do you have any ***drug allergies***? ☐ No ☐ Yes If yes, please list the medicine and the reaction:

SOCIAL HISTORY

Married: ☐ No ☐ Yes # of children: Present occupation:

If not currently working, date last worked: If not currently working, reason stopped:

SMOKING HISTORY

Do you currently smoke tobacco products? ☐ No ☐ Yes How many total years?

How many packs do you/did you average per day? packs

If no, have you ever smoked tobacco products in the past? ☐ No ☐ Yes

When did you stop smoking? Month / Year

ALCOHOL HISTORY

Do you drink alcohol products? ☐ No ☐ Yes If yes, how many drinks per day? Per week?

Have you ever required medical treatment for your alcohol intake? ☐ No ☐ Yes

RECREATIONAL DRUGS

Do you use recreational drugs? ☐ No ☐ Yes If yes, please describe:

REVIEW OF MEDICAL PROBLEMS

Do you have any other medical problems that have not already been listed? For example, consider problems with **heart, chest pain/tightness/pressure, lungs, shortness of breath, kidney, thyroid, pancreas, adrenal gland, diabetes, stomach ulcers, gastritis, arthritis, anemia, bone marrow, infections (tuberculosis, bladder infections, etc), epilepsy, stroke, depression, unusual stress at home or work, or other**

Please list below or write **NONE:**

1. 5.
2. 6.
3. 7.
4. 8.