*The Neurosurgery Center of Colorado*

# SPINE QUESTIONNAIRE

## Completed By Patient

Please complete the questionnaire before your clinic visits if possible. Please bring your form with you to the clinic. If you would like to complete the form in the clinic instead, or if you forget or loose your form, we will have forms available for you.

TODAY'S DATE ____________________

First Name _________________ Middle ____________Last_______________________

Your age________ The hand you use to write: Right _____ Left _____

Referring physician: _____________________________________________

## CHIEF COMPLAINT & PRESENT ILLNESS

What symptom bothers you the most? ________________________________________

When did the symptom begin? ______________________________________________

Did an injury cause this symptom? Yes _____ No _____

When did the injury occur: ____________________________

Describe how you were injured:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

Is litigation pending? Yes _____ No _____

## FOR THOSE WITH NECK OR ARM SYMPTOMS

If you have arm pain, which arm? Right _____ Left _____ Both _____

What does the pain feel like? aching ____ cramping ____ burning ____

sharp ____ stabbing ____ shooting ____ other ____________________

What makes the pain better? __________________________________________

What makes the pain worse? __________________________________________

| | | |
|---|---|---|
| Any numbness? | Yes _____ | No _____ |
| Any weakness? | Yes _____ | No _____ |
| Any problems walking? | Yes _____ | No _____ |
| Any bladder problems? | Yes _____ | No _____ |
| Any bowel problems? | Yes _____ | No _____ |

## FOR THOSE WITH BACK OR LEG SYMPTOMS

If you have leg pain, which leg? Right _____ Left _____ Both _____

What does the pain feel like? aching ____ cramping ____ burning ____

sharp ____ stabbing ____ shooting ____ other ____________________

What makes the pain better? __________________________________________

What makes the pain worse? __________________________________________

| | | |
|---|---|---|
| Any numbness? | Yes _____ | No _____ |
| Any weakness? | Yes _____ | No _____ |
| Any problems walking? | Yes _____ | No _____ |
| Any bladder problems? | Yes _____ | No _____ |
| Any bowel problems? | Yes _____ | No _____ |

In which way do the following affect your pain?

| | Increased | Decreased | No Affect |
|---|---|---|---|
| Sitting | ______ | ______ | ______ |
| Standing | ______ | ______ | ______ |
| Lying down | ______ | ______ | ______ |
| Bending | ______ | ______ | ______ |
| Lifting | ______ | ______ | ______ |
| Walking | ______ | ______ | ______ |
| Coughing | ______ | ______ | ______ |
| Sneezing | ______ | ______ | ______ |

## PREVIOUS TREATMENTS

What doctors have treated you for this condition?

________________________________________________________________

________________________________________________________________

What previous treatments have you had for your neck or back problem?

Bedrest ____ Exercise ____ Physical Therapy ____ Traction ____
Medications ____ Chiropractic ____ Epidural steroid injection ____
Other ________________________

Have the treatments helped you pain? Yes _____ No _____

What tests have been done? MRI ____ CT ____ Myelogram ____ EMG ____

## REVIEW OF SYSTEMS

Check if you have noticed any of the following:

general body weakness ____ fever ____ infection ____ weight loss ____ weight gain ____ change in appetite ____ shortness of breath ____ chest pain ____ abdominal pain ____ diarrhea ____ constipation____ bloody or tarry stools ____ nausea ____ vomiting ____ difficulty with urination ____ easy bruising ____ easy bleeding ____ rash or skin condition ____ joint pain ____ muscle pain ____ sleep apnea ____ anxiety ____ depression ____ panic attacks ____

## MEDICAL HISTORY

Do you have any of these medical illnesses?

asthma ____ cancer ____ (where and what type ________________________)

diabetes ____ allergies ____ emphysema ____ bronchitis ____ pneumonia ____

heart disease ____ palpitations ____ fast/slow heart rate ____ anemia ____

high blood pressure ____ liver disease ____ hepatitis ____ gastric reflux ____

ulcers ____ kidney disease/stones/infections ____ Lupus ____ seizures____

stroke or TIA ____ thyroid disease____ blood clots ____ fibromyalgia ____

arthritis ____ (Rhematoid ____ osteoarthritis ____) osteoporosis ____

chronic fatigue ____ other___________________________

List all the surgeries you have had in the past:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

List all your current medications:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Are you **allergic** to any **medications**, **latex** or **tape**? Yes ____ No ____ If yes, please list:

_____________________________________________________________________

_____________________________________________________________________

Do you smoke? Yes ____ No ____ If yes, how much per day? ____________________

For how many years? ____________________

## FAMILY HISTORY

Have members of your family such as **grandparents**, **parents**, **brothers, sisters,** or **children** had any serious illnesses? If so, please list:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

## SOCIAL HISTORY

Are you: single ____married ____ widowed ____

Are you: a homemaker ____ employed outside the home ____ retired ____

on disability ____

If employed outside the home, what type of work? ______________________________

Your signature: ______________________________________