ARIZONA SPINE CARE

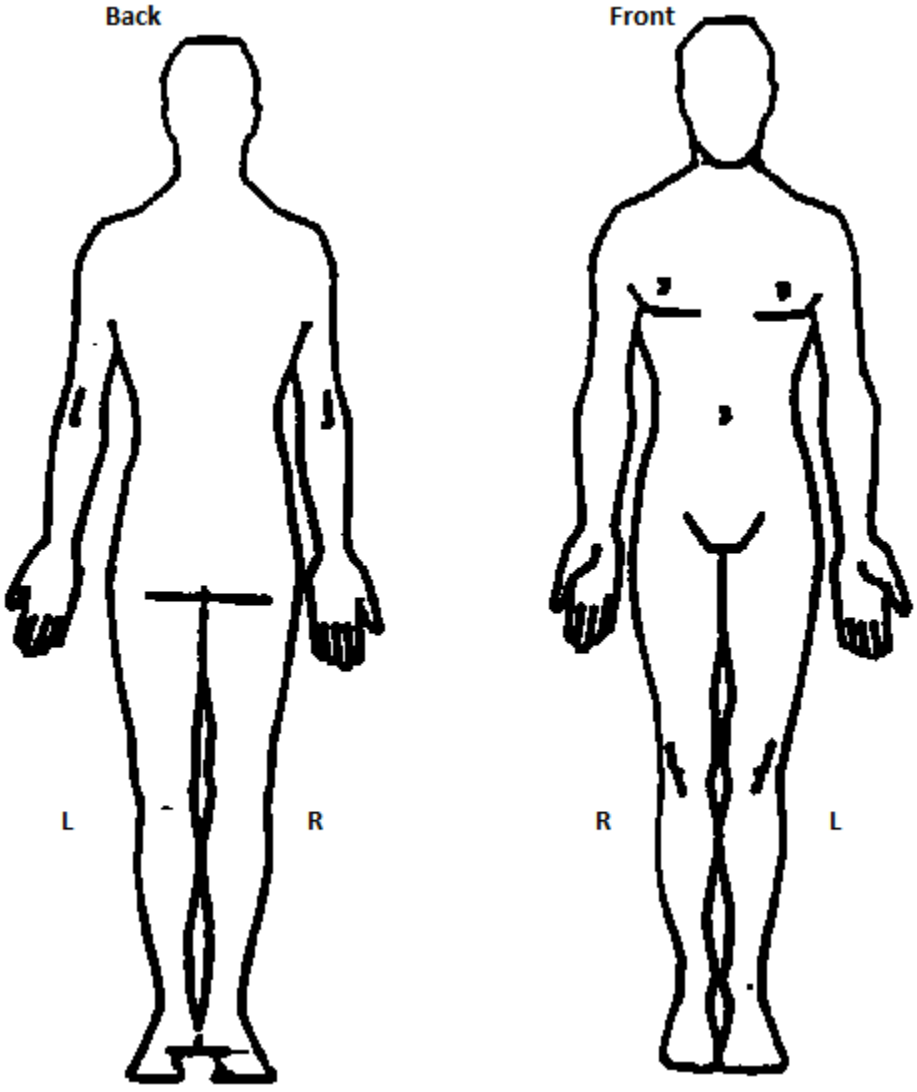
NEW PATIENT SPINAL QUESTIONNAIRE

Name: _____ Date of Appointment: _____
AZ Spine Care MR #:_____ Date of Birth: _____
Height: _____ Weight: _____ Age Today: _____

Pain Drawing

1. **Mark on the drawings below using the symbols (=, ^, O, /, X +) to best describe your pain quality.**

Numbness = = = = = = **Ache** ^ ^ ^ ^ ^ ^ **Pins and Needles** O O O O O O
Stabbing / / / / / / / / **Burning** X X X X X **Cramping** + + + + + +



2. Who referred you to Arizona Spine Care? **Please list information of who referred you to our office.**

____ 1. Primary doctor
____ 2. Physical therapist
____ 3. Patient
____ 4. Other

Name:_____
Address:_____
_____
Phone:_____ Fax:_____

If a doctor requested you visit Arizona Spine Care, please sign below if you wish to authorize the release of this and all subsequent reports to the above-named physician

I authorize this release. Signature: _____

Check here if you do NOT authorize this release: ☐

3. Which hurts you more, your legs or back? **(Check only ONE statement)**

____ 1. Legs hurt much more than back _____% back pain **(total of back and leg**
____ 2. Legs and back hurt about the same **percentage should**
____ 3. Back hurts much more than legs _____% leg pain **equal 100%)**

4. Which hurts you more, your neck or arms? **(Check only ONE statement)**

____ 1. Arms hurt much more _____% neck pain **(total of neck and arm**
____ 2. Neck and arms hurt about the same **percentage should**
____ 3. Neck hurts much more than arms _____% arm pain **equal 100%)**

5. Please **circle** the ONE number which best describes your current pain level.
0 represents no pain 10 is the worst pain you can imagine

0 1 2 3 4 5 6 7 8 9 10

5A. Severity of Pain: Minimal/ Slight / Moderate/ Severe

5B. Duration of Pain: Occasional / Intermittent/ Frequent/ Constant

6. How did your current episode begin? ____ 1. Suddenly ____ 2. Gradually
Describe:_____
_____
_____

7. How long ago did your current episode begin? Please give date:_____

____ 1. Less than 2 weeks ago
____ 2. 2 weeks to less than 8 weeks ago
____ 3. 8 weeks to less than 3 months ago
____ 4. 3 months to less than 6 months ago
____ 5. 6 to 12 months ago
____ 6. More than 12 months ago

8. Is this a work-related injury?
____ 1. Yes ____ 2. No Describe:_____
_____
If yes, date of injury:_____ _____

9. Have you been treated by a physical therapist for your current episode? ____1. Yes ___ 2. No

10. Have you had previous epidural injections for this episode? ____1. Yes ____2. No

11. Have you ever had back or neck surgery?

____ 1. Yes ____ 2. No If yes: How may surgeries? _____

12.

Date of spine surgery	Type of surgery	% Improvement	How long did the improvement last
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Please list all prescription medications and doses that you are ***currently*** taking: **NONE**:__

Medication	**Dosage**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. **Please list your local Pharmacy & Location:** _____

15. Are you ***Allergic*** **to any medications:** Please check: **Yes_____** **No_____**
Medication:_____ **Reaction**:_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction**:_____

Past Medical History

16. Please mark any of the following medical problems you have had: **NONE:_____**

____ 1. Ulcers
____ 2. Ulcerative colitis
____ 3. Psoriasis
____ 4. Arthritis (not spine related)
____ 5. Tuberculosis
____ 6. Cancer
____ 7. HIV positive
____ 8. Seizure
____ 9. Kidney/bladder infections
___ 10. Kidney stones
____ 11. Heart disease/heart attack
____ 12. Stroke
____ 13. Asthma
____ 14. Depression
____ 15. Prostate problems
____16. Hepatitis
____17. Diabetes
____ 18. High Blood Pressure
____ 19. Other _____

17. **Have you been hospitalized within the past 5 years? Why? When?:**_____
_____
_____

18. **List all previous surgeries:** **NONE**: _____

Date of surgery	**Type of surgery**	**Describe Recovery**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History (Do any members of your biological family have any of the following conditions?)

19. **Please *mark* conditions in your immediate family:** **NONE**: _____ **Unknown**:_____

____Cancer ____Diabetes ____Heart Disease ____Stroke
____Arthritis ____Back Pain ____Bleeding tendencies ____Anesthesia difficulties
____Malignant hyperthermia

Social History

20. Do you ***currently*** smoke cigarettes?
(Check only ONE statement)
____ 1. I have never smoked
____ 2. Yes: _____ packs per day
____ 3. No, I quit within the last 6 months
____ 4. No, I quit more than 6 months ago

21. Substance Abuse?
(Check only ONE statement)
____ 1. No
____ 2. Yes, once in a while
____ 3. Yes, often
If yes, type _____
Amount _____

22. Do you use alcoholic beverages (beer, wine, liquor)?
(Check only ONE statement)
____ 1. No
____ 2. Yes, once in a while
____ 3. Yes, often
If yes, type of alcohol beverage_____
Amount _____

23. Are you currently employed? ☐ **Yes** ☐ **No** ☐ **Retired**
What is your occupation? _____
Last date worked: _____

24. ***Review of Systems*** **NONE:_____**

Please ***MARK "X"*** next to any ***current*** symptoms your experiencing:

1. Skin:
   - ____rashes
   - ____psoriasis
   - ____bruise easily
   - ____abnormal lumps
   - ____painful breasts

2. Eyes:
   - ____visual loss
   - ____double vision

3. Ears
   - ____decreased hearing
   - ____ringing in ears

4. Nose
   - ____sinus problems
   - ____breathing problems

5. Throat
   - _____sore throat
   - _____hoarseness
   - _____snoring

6. Respiratory:
   - ____shortness of breath
   - ____wheezing
   - ____cough/ sputum production

7. Gastrointestinal:
   - ____weight loss
   - ____abdominal pain
   - ____nausea/vomiting
   - ____diarrhea or constipation
   - ____blood in stool
   - ____loss of bowel control

8. Musculoskeletal:
   - ____fractures/sprains
   - ____osteoporosis
   - ____joint swelling

9. Genitourinary:
   - ____blood in urine
   - ____increased frequency of urination
   - ____painful urination
   - ____loss of bladder control
   - ____kidney stones

10. Cardiovascular:
    - ____ palpitations/irregular heartbeat
    - ____chest pain
    - ____heart murmur/ rheumatic fever

11. Endocrine:
    - ____enlarged thyroid/goiter
    - ____excessive thirst/appetite
    - ____diabetes

12. Neurologic:
    - ____headache/migraine
    - ____dizziness
    - ____convulsions/seizures

Please take a moment to go over the questionnaire and make sure all questions have been completely answered. If all questions are not completely answered, it may cause a delay with your appointment.

REVISED 10/02/12