

Back Pain Questionnaire

Date: ____/____/____

Name: _____ Age: _____

Referring Doctor: _____

Are you right or left handed?

Are you currently working?

Does your pain keep you from working?

Employment:

Employer:

Are you involved in or considering litigation (law suits) related to your back/neck?

Do you want to a report sent to your lawyer?

What problem are you having now?

When in your life did you first experience back/neck pain?

Previous Spine Surgery

Please fill in the following if you have had previous surgery. "Pain free interval" means the period of time you felt well after the surgery before you felt the pain again. "Result" means your perception of how you did after the surgery. Please list additional spine operations on the back of this form.

Operation:	Surgeon:	Pain free interval:
Date:	Time off of work:	Result:

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When did you first notice your current pain?

Did the pain start suddenly or gradually?

Where were you when you first got the pain? (Home, work):

What has been done for the pain?

Has the character of location of your pain changed since you first noticed it?

Please circle any of the symptoms/diseases you have. Feel free to explain further.

General: Fevers, sweats, shaking chills, weight loss, blood clots

Endocrine: Diabetes, thyroid disease, osteoporosis, abnormal menstrual periods, increased back pain during your period

GI: Diarrhea, constipation, blood clots, incontinence

GU: Urinary incontinence, infections, kidney stones, renal failure, awaken to urinate

Head, eyes, ears, nose, throat: Glasses, sore throat, double vision, headache

Heart: Chest pain, heart attack, abnormal heart beats, hypertension, heart failure

Lungs: Short of breath, asthma, COPD, Pulmonary embolus

Neurological: Depression, anxiety disorder, under the care of a psychiatrist, drug addiction, alcohol abuse

Rheumatologic: Rheumatoid arthritis, Lyme disease, Ankylosing Spondylitis, Lupus

Skin: Psoriasis, skin cancer, rash, pitting of nails

How far can you walk?

Please answer the following questions by circling true or false. Feel free to add additional comments.

My leg/arm pain is worse when I cough or sneeze. _____ True or False

My leg(s)/arm(s) are weak. _____ True or False

My legs jump at night. _____ True or False

My pain keeps me awake at night. _____ True or False

My pain awakens me from sleep. _____ True or False

I have lost control of my bowel and bladder. _____ True or False

I enjoy my work. _____ True or False

What is your goal in seeing a Spine Surgeon?

Who do you feel is responsible for your back/neck problem?

Have you had any recent stressful life events such as a family crises, divorce or employment problem?

Are you receiving or contesting compensation or disability?

Medical History

Do you smoke?

(Please let me know if you smoke, how much and how long you have smoked, and if you quit, when)

Do you use alcohol?

(Please let me know how much and how often you drink alcohol.)

Please list all the medications you take (including prescription, nonprescription and social drugs)

Please list your allergies.

Please list any medical problems or past illnesses.

Please list any surgeries you have had of any kind in the past.

Have you been sick recently, specifically, have you have any fevers, chills, night sweats, noticed any bumps or moles or had any unexplained weight changes?

Is there anything that I haven't asked that you feel will help me understand your problem better?