



# PATIENT QUESTIONNAIRE

Date \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Your E-Mail \_\_\_\_\_

Fax Number (To Which Your Confidential Medical Information Can Be Sent) \_\_\_\_\_

Present Occupation \_\_\_\_\_ Previous Occupation? \_\_\_\_\_

Name of Spouse \_\_\_\_\_ (Or) Significant Other \_\_\_\_\_

Name, Address, and Specialty of Your Referring Health Professional \_\_\_\_\_

Referring Health Professional Phone# \_\_\_\_\_ Fax Number# \_\_\_\_\_

Name and Address of Your Primary Care Physician \_\_\_\_\_

Primary Care Physician Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Local Pharmacy Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Your Present Level of Activity \_\_\_\_\_

Do You Work Full-Time?  Yes  No

Does Your Present Problem Involve a Lawsuit or Motor Vehicle Accident?  Yes  No

Does Your Problem Involve a Worker's Compensation Claim?  Yes  No

If Yes, Give Name of Worker's Compensation Carrier: \_\_\_\_\_

Do You Have a Case Worker or QRC?  Yes  No If so who? \_\_\_\_\_

Have Any of Your Family Members Had Back Problems?  Yes  No

Have Any of Your Family Members Had Back Surgery?  Yes  No

Explain: \_\_\_\_\_

What Is Your Spine Problem at This Time? \_\_\_\_\_

How Long Has This Problem Been Present? \_\_\_\_\_

How Did the Problem Start?  Suddenly?  Gradually? Post-Injury?  Yes  No

If Injury, Was This a Work-Related Injury?  Yes  No If Yes State Date and Circumstances: \_\_\_\_\_

Have You Had Other Significant Spine Injuries in the Past?  Yes  No

What Makes Your Pain Worse?  Lifting  Bending  Twisting  
(Check All That Apply)  Sitting  Standing  Walking  
 Running  Lying Down  Position Change  
 Sleeping  Coughing  Sneezing  Straining

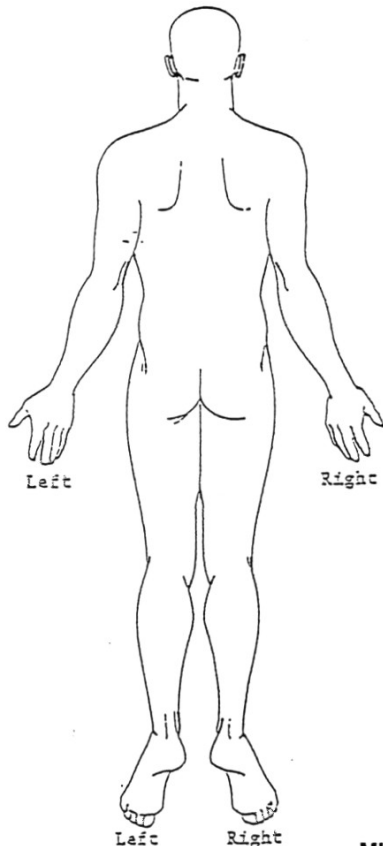
What Makes Your Pain Better?  Lying Down  Sitting  Standing

(Check All That Apply)  Pain Meds  Anti-Inflammatories  Walking

At This Time Please Fill Out the Pain Drawing Below:

Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHING: ===== PINS & NEEDLES: 0000 BURNING: XXXX SHARP & STABBING: ///



Left Right

1. % PAIN IN LOW BACK \_\_\_\_\_

2. % PAIN IN RT. BUTTOCK \_\_\_\_\_

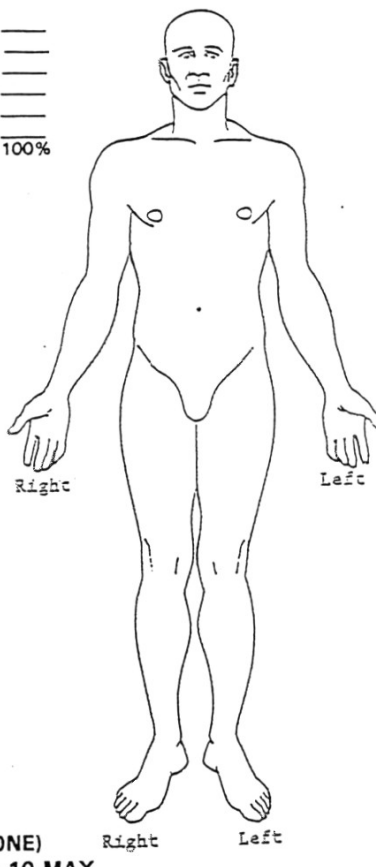
3. % PAIN IN LT. BUTTOCK \_\_\_\_\_

4. % PAIN IN RIGHT LEG \_\_\_\_\_

5. % PAIN IN LEFT LEG \_\_\_\_\_

6. % PAIN ELSEWHERE \_\_\_\_\_

TO TOTAL: 100%



Right Left

**PAIN SCALE (CIRCLE ONE)**  
**MINIMAL 1 2 3 4 5 6 7 8 9 10 MAX**

Choose no more than five that describe your pain. Please (X). Most important (XX).

- |                    |                     |                   |                    |
|--------------------|---------------------|-------------------|--------------------|
| 1. Steady [ ]      | 5. Intermittent [ ] | 9. Electrical [ ] | 13. Throbbing [ ]  |
| 2. Tiring [ ]      | 6. Punishing [ ]    | 10. Killing [ ]   | 14. Miserable [ ]  |
| 3. Crawling [ ]    | 7. Boring [ ]       | 11. Gnawing [ ]   | 15. Heavy [ ]      |
| 4. Suffocating [ ] | 8. Cruel [ ]        | 12. Annoying [ ]  | 16. Unbearable [ ] |

If There is Weakness of a Arm or Leg Show it in the Drawing Above:

Which of These Diagnostic Studies Have You Had?

MRI  CT Scan  Plain X-Rays  Myelogram  EMG

Which of the Following Have You Had for this Current Problem? (Check All That Apply)

Oil Myelogram  Chiropractic Care  Physical Therapy

Epidural Steroid Injection  Trochanteric Injection  Facet Injections

List Current Pain, Anti-Inflammatory, and Anti-Spasm Medications Below:

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List All Other Present Medications Below (Please Attach List if Space is Inadequate):

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Are You on Any Anti-Coagulant Drugs at This Time?    \_\_\_Yes    \_\_\_No

Are You on Any Steroids at This Time?    \_\_\_Yes    \_\_\_No

Are You Allergic to Any Medications?    \_\_\_Yes    \_\_\_No

If Yes, List These Medications and Your Reaction to Them: \_\_\_\_\_

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PRESENT SYSTEM REVIEW: (Check All Items Which Apply to You)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Excessive Stress    | <input type="checkbox"/> Heart Problems                | <input type="checkbox"/> Cancer                                    |
| <input type="checkbox"/> Bladder Problems    | <input type="checkbox"/> Irregular Heart Rate          | <input type="checkbox"/> Painful Joints                            |
| <input type="checkbox"/> Bowel Problems      | <input type="checkbox"/> Frequent Chest Pain           | <input type="checkbox"/> Seizures or Blackouts                     |
| <input type="checkbox"/> Stomach Problems    | <input type="checkbox"/> Frequent Shortness of Breath  | <input type="checkbox"/> Severe Headaches                          |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Bleeding or Bruising Tendency | <input type="checkbox"/> Significant Weight Gain<br>or Weight Loss |

PAST MEDICAL HISTORY REVIEW (Check Items Which Have Been Issues for You)

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures      |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Suicide       |

PATIENT SPINE RELATED SURGICAL HISTORY (List Below)

Procedure	Date	Hospital Location	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NON-SPINE RELATED SURGICAL HISTORY (Please List)

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FAMILY HISTORY

(Check off those involving immediate family and add identification as to:

Mother= (M)      Father= (F)      Siblings= (S)      Grandparents= (G)

\_\_\_\_\_ Back Problems      \_\_\_\_\_ Genetic (Genomic) Back Problems      \_\_\_\_\_ Scoliosis  
Identify Family Members Who Have Had Back Surgery\_\_\_\_\_

_____ Abnormal Bleeding	_____ Heart Disease	_____ Lupus
_____ Anesthesia Problems	_____ Hepatitis	_____ Neck Problems
_____ Cancer (Type)	_____ High Blood Pressure	_____ Osteoporosis
_____ Depression	_____ High Cholesterol	_____ Rheumatoid Arthritis
_____ Diabetes	_____ Lung Problems	_____ Seizures

SOCIAL HISTORY

Married? \_\_\_Yes \_\_\_No      Children \_\_\_Yes \_\_\_No      If Yes Ages\_\_\_\_\_

Cigarette Smoker? \_\_\_Yes \_\_\_No      If Yes Give Amount per Day\_\_\_\_\_ # Years\_\_\_\_\_

List Any Other Nicotine Products That You Use\_\_\_\_\_

Are You Aware That Smokers Have a 3-4x Higher Incidence of Disc Degeneration Than Non-Smokers? \_\_\_Yes \_\_\_No

Alcohol Consumption? \_\_\_Yes \_\_\_No      Amount? Week\_\_\_\_\_

Do You Exercise Now? \_\_\_Yes \_\_\_No      Daily? \_\_\_Yes \_\_\_No

Type of Exercise\_\_\_\_\_

No, What Exercise Have You Done in the Past?\_\_\_\_\_

Have You Had A Chemical Dependency or Drug Addiction Problem? \_\_\_Yes \_\_\_No

Yes State the Number of Years You Have Been Drug Free\_\_\_\_\_

Who Prescribes Your Narcotic Medications?\_\_\_\_\_

Who Prescribes Your Other Medications?\_\_\_\_\_

Signature or Title of the Person Actually Filling Out This Form\_\_\_\_\_

Relationship to Patient\_\_\_\_\_

Date When Form Filled Out\_\_\_\_\_

IF A LAWSUIT

Explain \_\_\_\_\_

Attorney Contact Information \_\_\_\_\_

Attorney Phone # \_\_\_\_\_

IF A MOTOR VEHICLE ACCIDENT

Explain \_\_\_\_\_

Give Date \_\_\_\_\_ Auto Carrier's Name \_\_\_\_\_

Claim# \_\_\_\_\_ Adjuster's Name \_\_\_\_\_

Adjuster Phone \_\_\_\_\_ Adjuster Fax \_\_\_\_\_

IF A WORKERS COMPENSATION CASE

Date of Injury \_\_\_\_\_ Circumstance of Injury (Explain) \_\_\_\_\_

Name of Work Comp Carrier \_\_\_\_\_

Name of Your Employer \_\_\_\_\_ Phone \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Adjuster's Address \_\_\_\_\_

Adjuster's Phone \_\_\_\_\_ Adjuster's Fax \_\_\_\_\_

Do You Have a Case Worker?  Yes  No or a QRC?  Yes  No

If Yes Who? \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address of Caseworker or QRC \_\_\_\_\_

INSURANCE INFORMATION

Primary Insurer \_\_\_\_\_ Secondary Insurer \_\_\_\_\_

Insurer Address \_\_\_\_\_ Sec. Insurer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ ID# \_\_\_\_\_ Policy/ ID# \_\_\_\_\_

Group# \_\_\_\_\_ Effective Date \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_ Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_

Your Employer's Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Is a Referral Required for You to be Seen in Our Clinic?  Yes  No

NOTE: If Your Insurance Requires a Referral, and if Such is Not Provided, You Will be Responsible for the Payment of All Charges. All Co-payments are Due at the Time of the Appointment.

I Understand, and Confirm, That the Above Information is Accurate

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date