

CONSULTATION EXPRESS® QUESTIONNAIRE

Date_____

Name_____Date of Birth_____Present Age_____

Soc Sec#_____Home Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____

E-Mail Address (To Which Your Confidential Medical Information Can Be Sent)_____

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

Present Occupation_____Previous Occupation?_____

Name and Address of Your Primary Care Physician_____

Primary Care Physician Phone#_____Fax Number_____

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

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:

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

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

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:

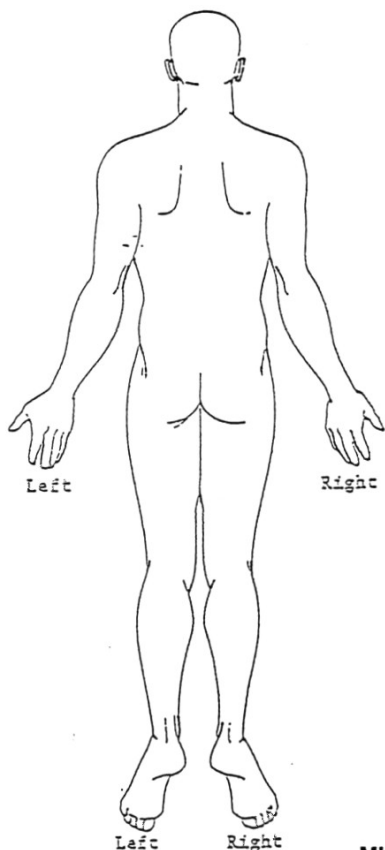
Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHING: =====

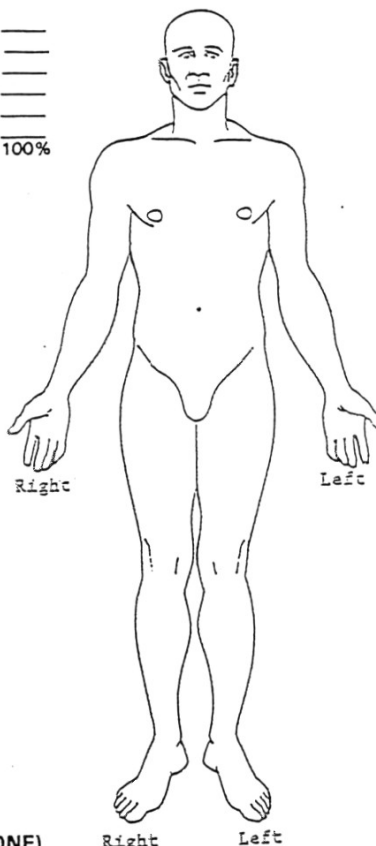
PINS & NEEDLES: 0000

BURNING: XXXX

SHARP & STABBING: ///



- 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%



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:

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

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: _____

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

- | | | |
|-------------------------|-----------------------------------|--|
| ___ Excessive Stress | ___ Heart Problems | ___ Cancer |
| ___ Bladder Problems | ___ Irregular Heart Rate | ___ Painful Joints |
| ___ Bowel Problems | ___ Frequent Chest Pain | ___ Seizures or Blackouts |
| ___ Stomach Problems | ___ Frequent Shortness of Breath | ___ Severe Headaches |
| ___ Frequent Infections | ___ Bleeding or Bruising Tendency | ___ Significant Weight Gain or Weight Loss |

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

- | | | |
|----------------|-------------------------|-------------------|
| ___ Arthritis | ___ Heart Disease | ___ Neck Problems |
| ___ Cancer | ___ Hepatitis | ___ Osteoporosis |
| ___ Depression | ___ High Blood Pressure | ___ Seizures |
| ___ Diabetes | ___ High Cholesterol | ___ Suicide |

PATIENT SPINE RELATED SURGICAL HISTORY (List Below)

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

PATIENT NON-SPINE RELATED SURGICAL HISTORY (Please List)

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_____