OrthopedicSpecialists

Spine Questionnaire
for Michael C. Chabot, D.O.

Name: _____ Age: _____ Date of Visit: _____

Primary Care Physician: _____

Referring Physician / Agency: _____

For Purpose of: _____

What are your current symptoms? _____

How long has the problem been present? _____ Years _____ Months

Are your symptoms associated with an injury? ☐ Yes ☐ No

Date of injury: _____ Where did injury occur? _____

To which area of body? ☐ Neck(base of skull to shoulders) ☐ Mid Back ☐ Low Back

Describe injury: _____

Prior Treatment:

Have you taken any medicine for your complaints? (please list) _____

Have you been medically treated for this present problem? ☐ Yes ☐ No

Treated by Dr(s): _____

Treatment prescribed: _____

Prior Diagnostic Studies Performed: (check all that apply)

☐ X-rays ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Nerve Studies ☐ Bone Scan

When? _____ Facility Name & Location? _____

Does Back/Neck Pain Radiate Into: LEGS? ☐ Yes ☐ No ARMS? ☐ Yes ☐ No

Pain Confined to: ☐ BACK ☐ NECK ☐ BOTH

LOW BACK/NECK PAIN ONLY

How severe was pain initially? ☐ Mild ☐ Moderate ☐ Severe

How severe is pain now? ☐ Mild ☐ Moderate ☐ Severe

Pain is: ☐Sharp ☐Dull ☐Aching ☐Generalized ☐Localized ☐Cramping ☐Burning ☐Electric/Shocking

PAIN RADIATING INTO LEGS OR ARMS

Pain is: ☐Sharp ☐Dull ☐Aching ☐Generalized ☐Localized ☐Cramping ☐Burning ☐Electric/Shocking

Do you have numbness in the leg(s) or arm(s)? ☐ Yes ☐ No Describe location:_____
(circle appropriate limb)

Do you have weakness in the leg(s) or arm(s)? ☐ Yes ☐ No Describe location:_____
(circle appropriate limb)

Symptoms are worsened by: ☐Standing ☐Walking ☐Sitting ☐Lying Down/Resting ☐Coughing/Sneezing ☐Bending Forward/Bending Backwards

Symptoms are improved by: ☐Standing ☐Walking ☐Sitting ☐Lying Down/Resting ☐Coughing/Sneezing ☐Bending Forward/Bending Backwards

There has been **no loss / some loss** of bowel or bladder control.
(circle one)

Has your ability to walk long distances been reduced? ☐ Yes ☐ No
How far can you walk before pain or symptoms stop you? Specify _____ blocks (one block = 100 feet)
Is there loss of erection? ☐ Yes ☐ No

Do you have a history of a previous back/neck injury? ☐ Yes ☐ No
Sought medical treatment on (date) _____ from Dr. _____
What was your diagnosis? _____
Was it work-related? ☐ Yes ☐ No
Comments: _____

Past Medical History: (please circle any conditions you have or have had in the past)

High Blood Pressure	Seizures	Head Injury
Low Blood Pressure	Multiple Sclerosis	Paralysis
Asthma	Parkinson's Disease	Neck Pain/Neck Injury
Shortness of breath	Thyroid Disease	Back Pain/Back Injury
Emphysema	Kidney Disease	Numbness in Hands
Chronic Cough	Liver Disease	Numbness in Feet
Tuberculosis	Hepatitis A, B, or C	Spinal Fracture
Coronary Artery Disease	Irritable Bowel Syndrome	Spinal Stenosis
Angina	Gastritis/Peptic Ulcer Disease	Herniated Disc in Neck/Back
Cardiac Arrhythmia/A-Fib	GI Bleeding	Cancer – what type?_____
Heart Attack	Constipation*	Diabetes – how many years?_____
Congestive Heart Failure	Enlarged Prostate/Urinary Retention**	Peripheral Neuropathy
Mitral Valve Prolapse	Endometriosis	Peripheral Vascular Disease
Blood Clots	HIV	Depression
Anemia	Arthritis (Hip, Knee, Shoulder)	Anxiety
Bleeding Problems	Osteopenia/Osteoporosis	Bipolar Disorder
Stroke		Schizophrenia

*If yes (Constipation):
How often do you have a bowel movement? _____ How long have you had this issue? _____
What treatment have you tried for this issue? _____

**If yes (Urinary Retention/Enlarged Prostate):
How often do you urinate over the course of the night? _____ Do you pass small medium or large volumes at a time? _____ Have you taken any medication for this condition? (example: Flomax (Tamsulosin)? _____

Have you or are you being treated for any other condition or disease not listed above? If yes, please list:

_____

Have you been treated for an emotional/psychiatric disorder? ☐ Yes ☐ No
Have you been hospitalized for a psychiatric condition? ☐ Yes ☐ No
Have you had ECT treatment? ☐ Yes ☐ No
Have you been drug/chemically dependent? ☐ Yes ☐ No
Are you currently drug/chemically dependent? ☐ Yes ☐ No

Surgeries (List All Surgeries)	**Dates**

Any Problems with Anesthesia? Yes / No

Medications (List All)	

Allergies (List All Medication Allergies & Your Reaction)

Pharmacy Information

Pharmacy Name: _____

Phone # _____

Fax # _____

Family History: *(Check those that apply)*

	Mom	**Dad**	**Sibling**
Heart Disease/MI	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Cancer type _____	☐	☐	☐
Diabetes	☐	☐	☐
Asthma	☐	☐	☐
Seizures	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Thyroid Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Mental Illness	☐	☐	☐
Acid Reflux/Ulcer	☐	☐	☐
Unknown	☐	☐	☐
None	☐	☐	☐

Social History:

Do you smoke? Yes / No
Packs per day? _____ for _____ years

Do you drink alcohol? Yes / No
Drinks per week? _____

Do you have a history of drug or alcohol abuse? Yes / No

Do you use a cane, walker, wheelchair? Yes / No
(circle one)

Are you married? Yes / No

Does someone live at home with you? Yes / No

Level of education _____

Are you presently pregnant? Yes / No
If yes, E.D.C _____

Additional comments: _____

_____

_____

Employment Information:

Employment Title: _____

Description of Duties: _____

You are currently working ▪ regular duty ▪ light duty ▪ off duty

If you are not working, what was your last date of employment? _____

Job duties require:

_____ Lifting: Weight range	____ lbs.	____ continuously	____ frequently	____ occasionally
_____ bending and squatting		____	____	____
_____ sitting		____	____	____

General:

Your general state of health is: ____ Excellent ____ Good
____ Fair (elaborate)_____
____ Poor (elaborate)_____

Height: _____ Weight: _____ lbs. _____ with no change
_____ recent significant weight GAIN of _____ lbs.
_____ recent significant weight LOSS of _____ lbs.

(PLEASE GO TO THE NEXT PAGE)

Pain Level Shortly After Injury

* Circle the number on the line below that represents your pain at its least.

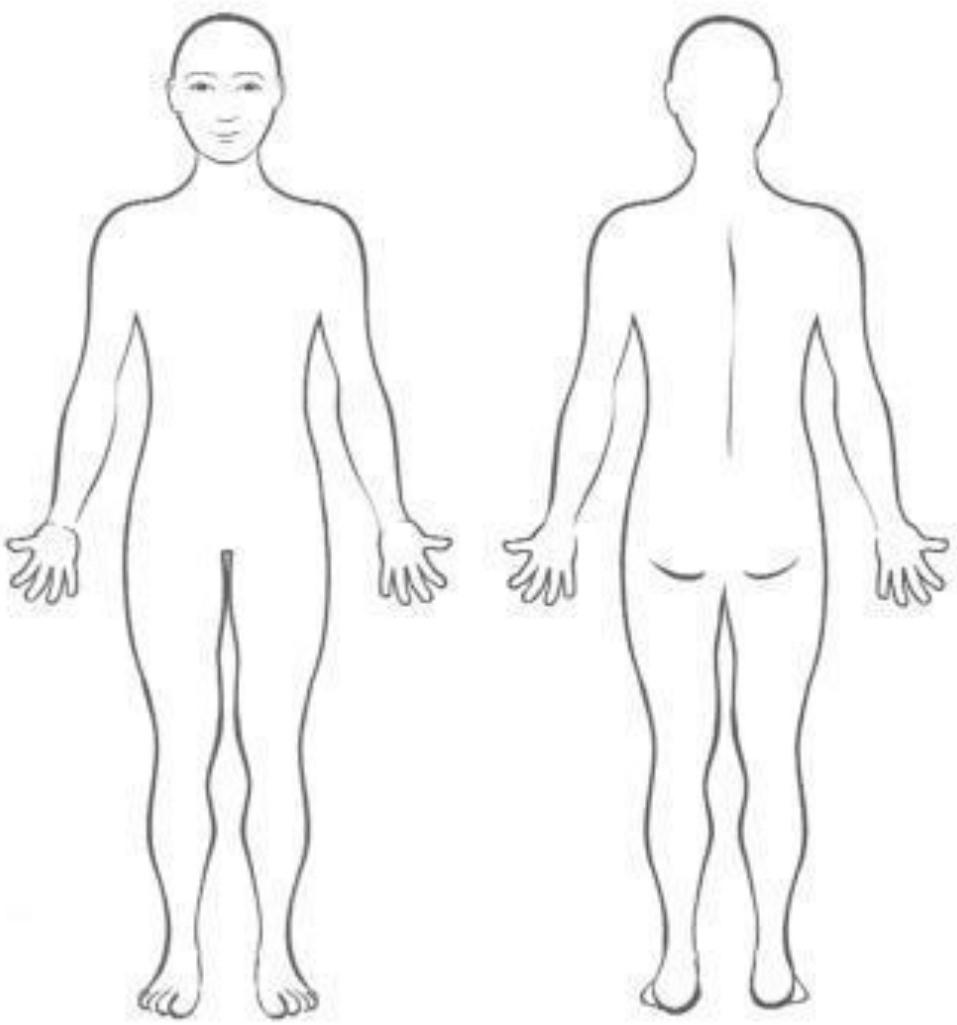
* Circle the number on the line below that represents your pain at its worst.

* Place an "X" on the line below that represented your pain **shortly after the injury**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain was located and what type of pain you were experiencing **shortly after the injury** **(If there was no injury, skip to the next page).** Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching



Pain Level Today

* Circle the number on the line below that represents your pain at its least.

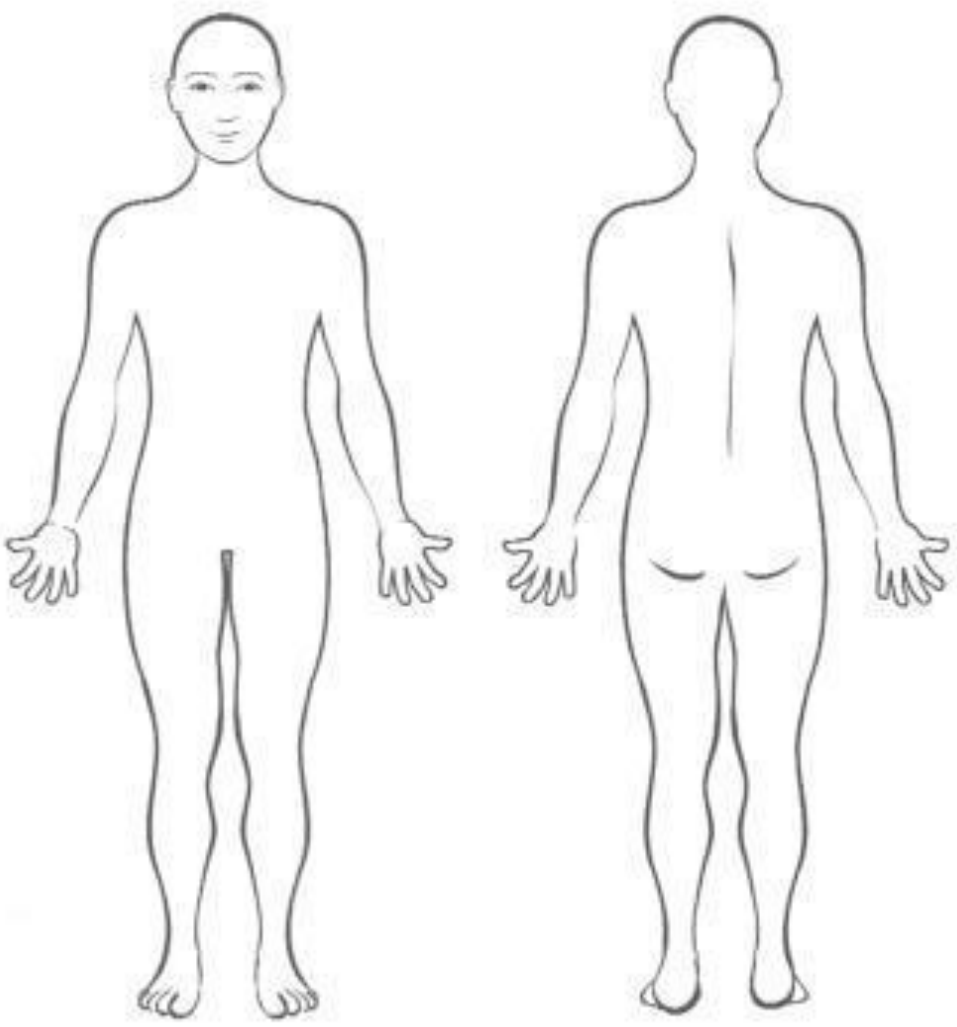
* Circle the number on the line below that represents your pain at its worst.

* Place an "X" on the line below that represents your pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching



----------For Office Use Only----------

Review of Systems:

General:

Gait:

Integument:

HEENT:

Neck:

Lungs:

Cardiovascular:

GI:

GU:

Psychological:

Joints:

Hematologic:

Musculoskeletal:

Neurologic:

----------For Office Use Only----------

Physical Examination:

General:

Gait:

Integument:

HEENT:

Neck:

Lungs:

Cardiovascular:

Abdomen:

Psychological:

Joints:

Musculoskeletal:

Neurologic:

Vascular:

PLAN

DIAGNOSTICS:
Cervical MRI
Thoracic MRI
Lumbar MRI
Bilat **UE**—EMG/NCV
Bilat **LE**—EMG/NCV
Cervical myelo/CT
Thoracic myelo/CT
Lumbar myelo/C T
DEXA (bone density)
Arterial Doppler, BLE, w/ex
Cervical CT w/ recons
Lumbar CT w/ recons
Bone scan
Cervical disco/CT
Lumbar disco/CT
Cervical MRI w & w/o Gadolinium
Lumbar MRI w & w/o Gadolinium

MEDS:
Naproxen
Ibuprofen
Mobic
Celebrex
Soma
Tizanidine
Flexeril

Norco
Percocet
Ultram

Medrol Dose Pak
Neurontin

INJECTIONS:
Cervical ESI
Lumbar **TF** ESI
Lumbar **IL** ESI

Cervical SNRI
Lumbar SNRI

Cervical facet joint
Lumbar facet joint

Hip joint inj under fluoro
SI joint inj under fluoro

THERAPY:
physical therapy
work-conditioning
work-hardening
HEP

IN-OFFICE Injections:
sacroiliac injections _____
trigger point injections X _____
muscle groups _____
_____
ITB injections _____
hip bursa injection(s) _____
knee injection(s) _____
carpal tunnel injection _____
ulnar nerve injection _____
AC joint injection _____
glenohumeral jt inj _____

OTHER RECOMMENDATIONS:_____ **F/U**_____