Name: _____ DOB: _____ Date: _____

TOTAL ORTHOPEDICS
SPORTS & SPINE

**Patient Questionnaire**

Please print off, complete by hand and bring with you to your appointment.

1. Select ONE as your primary symptom
    1. Low back pain
    2. Mid back pain
    3. Neck pain
    4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
    5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
    6. Arm pain, numbness or tingling. Left Right or Both
    7. Shoulder pain. Left Right or Both
    8. Headache
    9. Other _____
2. In addition to your primary symptom noted above, what OTHER symptoms do you have?
    1. Low back pain
    2. Mid back pain
    3. Neck pain
    4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
    5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
    6. Arm pain, numbness or tingling. Left Right or Both
    7. Shoulder pain. Left Right or Both
    8. Headache
    9. Other _____

3. Symptoms Assessment: Please rate your CURRENT symptoms: (0=no pain, 10=severe)

    With regard to your Neck: 0 1 2 3 4 5 6 7 8 9 10

    With regard to your Arms: 0 1 2 3 4 5 6 7 8 9 10

    With regard to your Back: 0 1 2 3 4 5 6 7 8 9 10

    With regard to your Legs: 0 1 2 3 4 5 6 7 8 9 10

4. What was the onset date of your symptoms or your injury? _____

5. How frequently do your symptoms occur? _____

6. How have your symptoms progressed since the date of symptoms? (Please circle ONE)

    Consistent Gradually Improving Rapidly Improving Gradually Worsening

    Rapidly Worsening

7. Place an X by the treatment or diagnostic tests you have had for your spine symptoms.
___ Medications What type? Anti-inflammatory, Muscle relaxant, Medrol Dose Pack, Prednisone, Pain Medications, other _____
___ Physical Therapy (date) _____
___ Chiropractic Care (date) _____
___ Massage
___ X-Ray (date) _____
___ CT Scan (date) _____
___ MRI Scan (date) _____
___ Myelogram (date) _____
___ EMG (date) _____
___ Epidural steroid injection (date) _____
___ Diagnostic nerve block (date) _____
___ Other _____

8. How much relief have you had from these treatments? (Please circle)

No relief  Mild relief  Moderate relief  Significant relief

9. Have you had surgery on your **NECK**? Yes No
Date of most recent **Neck** surgery _____
Name of Surgeon: _____

What type of NECK surgery:
____ Discectomy
____ Microdiscectomy
____ Laminectomy
____ Fusion
____ Other_____

Have you had surgery on your **BACK**? Yes No
Date of most recent **Back** surgery _____

Name of Surgeon: _____

What type of BACK surgery:
____ Discectomy
____ Microdiscectomy
____ Laminectomy
____ Fusion
____ Other _____

10. Are your symptoms related to a Motor Vehicle Accident (MVA)? Yes or No

If Yes, Date(s): _____

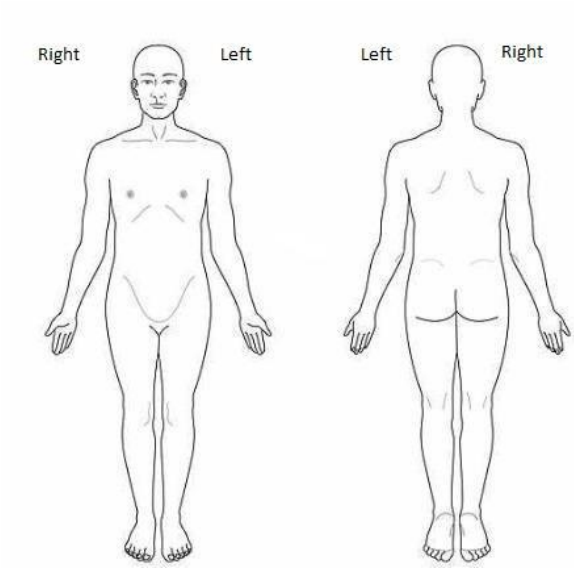
11. Are your symptoms recognized as a workers compensation injury? Yes No Undetermined
Please explain:
_____

12. Work History: Current occupation: _____
Employer: _____
Are you currently working? Yes or No
Physical demands of work: ___Sedentary ___ Mild ___ Moderate ___ Heavy
Have you missed work due to your current symptoms? Yes No
Please explain:_____
Have you been given work restrictions by your physician? Yes No
Please list:_____
Have you been given a workers compensation disability rating in the past for your spine symptoms? Yes No Unknown
What was the rating? _____ By whom? _____

13. Have you been referred to any other specialists for evaluation of your spine symptoms?
    Yes No Please list _____

14. Mark these drawings according to where you hurt. Please indicate which sensation you feel by referring to the key below.

    Key: Stabbing /// Burning XXX Pins and Needles 000 Numbness === Aching +++




15. Please note if the following improve or worsen your symptoms.

| Improve | Worsen | Unchanged | | Improve | Worsen | Unchanged | |
|---|---|---|---|---|---|---|---|
| _____ | _____ | _____ | Sitting | _____ | _____ | _____ | Laying Down |
| _____ | _____ | _____ | Standing | _____ | _____ | _____ | Cough/sneeze/strain |
| _____ | _____ | _____ | Bending | _____ | _____ | _____ | Computer/Desk work |
| _____ | _____ | _____ | Walking | _____ | _____ | _____ | Lifting |

16. Pain is… (Please circle which ONE applies)
    Same all the time Worse during the day Worse at night

17. Is this your first episode of pain or have you had recurrent episodes? First episode: Yes No
    Recurrent, how many? _____ Date of Most Recent Episode: _____

18. Please rate the quality of your sleep _____ Poor _____ Fair _____ Good _____ Excellent

Thank you for completing the Total Orthopedics Sports & Spine.

Comments:_____

_____

Patient signature: _____ Date: _____