

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs.

Referring doctor's name & address: _____

Internist or family doctor's name & address: _____ Same as above

A. Chief Complaint

1. What is your MAIN reason for seeing the doctor? (Check all that apply)

___ Neck pain Arm, shoulder, or hand: ___ Pain ___ Numbness ___ Weakness

___ Back pain Leg, buttock, or foot: ___ Pain ___ Numbness ___ Weakness

___ Other: _____

2. How long have you had this problem? _____

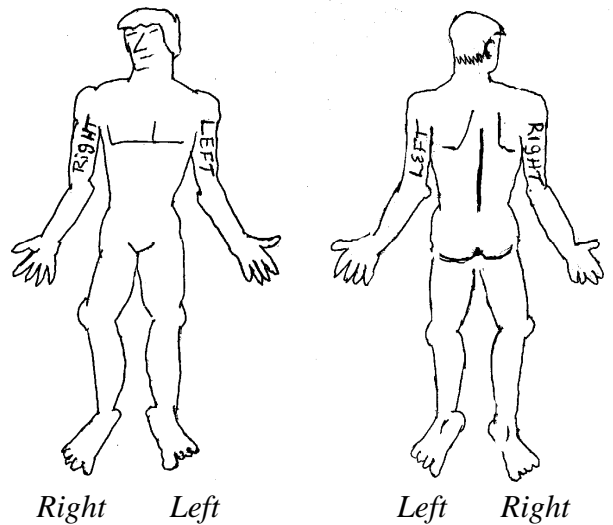
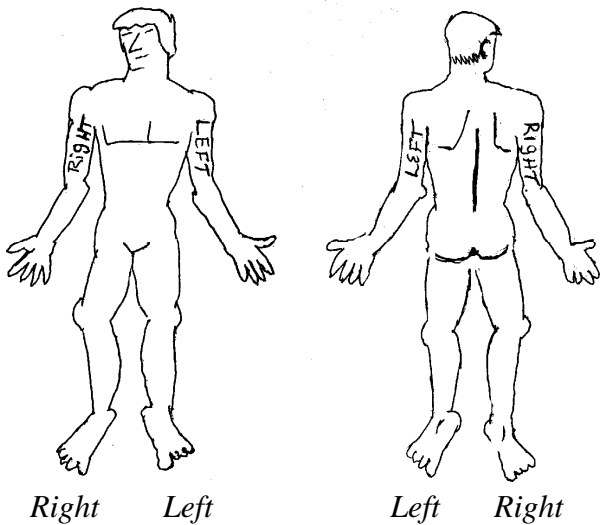
3. Has this problem recently gotten worse? YES / NO If YES, when? _____

4. What started the problem? _____

B. Pain and Numbness Diagrams

Mark where you have PAIN

Mark where you have NUMBNESS or TINGLING



My pain level is (circle one): 0 1 2 3 4 5 6 7 8 9 10
None Slight Moderate Severe Extreme Could not be worse

C. Complete this section for NECK/ARM problems ONLY.

1. What portion of your pain is in your **NECK versus your ARM(s)**? (Check only one)

- No neck or arm pain NECK and ARM pain are about equal (50/50)
 All NECK pain, no arm pain Mostly ARM pain, only some neck pain
 Mostly NECK pain, some arm pain All ARM pain, no neck pain

2. What portion of your **ARM PAIN** is on the **RIGHT versus LEFT**? (Check only one)

- No arm pain RIGHT and LEFT arms are about equal (50/50)
 RIGHT arm pain, no left arm pain Mostly LEFT arm pain, some right arm pain
 Mostly RIGHT arm pain, some left arm pain LEFT arm pain, no right arm pain

3. If you have **ARM PAIN**, where do you feel it? (Check all that apply)

- RIGHT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small
LEFT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small

4. If you have **ARM NUMBNESS**, where do you feel it? (Check all that apply)

- RIGHT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small
LEFT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small

5. If you have **ARM WEAKNESS**, where do you feel it? (Check all that apply)

- RIGHT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small
LEFT: Shoulder Arm Forearm FINGERS: Thumb Index Long Ring Small

6. Are you **right- or left-handed**? (Circle one) **RIGHT** **LEFT**

7. Please indicate which, if any, of these problems you are experiencing. (Check all that apply)

- Pain or numbness that is *worse at night* than during the day
 Pain or numbness that is *worse with overhead activity* (e.g., washing or drying hair)
 Difficulty *picking up small objects* (e.g., keys, coins) or *buttoning shirts*
 New difficulty with *handwriting or penmanship*
 Problems with *balance or frequent tripping*
 Headaches in the *back of the head*

D. Complete this section for **BACK/LEG** problems **ONLY**.

1. What portion of your pain is in your **BACK versus your LEG(s)**? (Check only one)

- | | |
|--|--|
| <input type="checkbox"/> No back or leg pain | <input type="checkbox"/> BACK and LEG pain are about equal (50/50) |
| <input type="checkbox"/> All BACK pain, no leg pain | <input type="checkbox"/> Mostly LEG pain, only some back pain |
| <input type="checkbox"/> Mostly BACK pain, some leg pain | <input type="checkbox"/> All LEG pain, no back pain |

2. What portion of your **LEG PAIN** is on the **RIGHT versus LEFT**? (Check only one)

- | | |
|--|--|
| <input type="checkbox"/> No leg pain | <input type="checkbox"/> RIGHT and LEFT legs are about equal (50/50) |
| <input type="checkbox"/> RIGHT leg pain, no left leg pain | <input type="checkbox"/> Mostly LEFT leg pain, some right leg pain |
| <input type="checkbox"/> Mostly RIGHT leg pain, some left leg pain | <input type="checkbox"/> LEFT leg pain, no right leg pain |

3. If you have **LEG PAIN**, where do you feel it? (Check all that apply)

- RIGHT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot
- LEFT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot

4. If you have **LEG NUMBNESS**, where do you feel it? (Check all that apply)

- RIGHT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot
- LEFT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot

5. If you have **LEG WEAKNESS**, where do you feel it? (Check all that apply)

- RIGHT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot
- LEFT: Buttock Groin Front of thigh Side of thigh Back of thigh Calf Foot

6. How far can you walk before **LEG PAIN** makes you stop and rest? (Check only one)

- | | |
|---|---|
| <input type="checkbox"/> I cannot stand up | <input type="checkbox"/> 1 or 2 blocks |
| <input type="checkbox"/> Across the room | <input type="checkbox"/> 1 or 2 miles |
| <input type="checkbox"/> Across the parking lot | <input type="checkbox"/> I can walk as far as I want without leg pain |

7. Is there anything else that keeps you from **WALKING** very far? (Check all that apply)

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Poor balance |

8. What happens to your **LEG PAIN** with the following activities? (Check all that apply)

- | | |
|--|--|
| <i>Lying down:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change | <i>Walking:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change |
| <i>Sitting:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change | <i>Bend forward:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change |
| <i>Standing:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change | <i>Bend back:</i> <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> No change |

F. Past Medical History (Check all that apply) ___NONE

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia, frequent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Polio | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Organ transplants | <input type="checkbox"/> Blood clot in legs | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Cancer of _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clot in lungs | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Injury of _____ |
| <input type="checkbox"/> How long? _____ | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Mental illness | <input type="checkbox"/> OTHER: _____ |

G. Past Surgical History (List all previous surgeries, especially any surgeries on neck, chest, or back; write on back if needed) ___NONE

Operation	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

H. Review of Systems (Check all that apply) ___NONE

- | | | | |
|--|---|---|--|
| PATHOLOGIC | PULMONARY | <input type="checkbox"/> Double vision | <input type="checkbox"/> New moles/dark spots |
| <input type="checkbox"/> Fevers or chills | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Frequent headaches | CONSTITUTIONAL |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Blackouts or seizures | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Pain worse at night | <input type="checkbox"/> Green/yellow sputum | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Gum or tooth problems |
| <input type="checkbox"/> Unusual weight loss | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Anorexia or bulimia |
| <input type="checkbox"/> Sudden weight gain | <input type="checkbox"/> Bad or loud snoring | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor nutrition |
| <input type="checkbox"/> No position of relief | <input type="checkbox"/> Frequent hoarseness | <input type="checkbox"/> Nervous exhaustion | <input type="checkbox"/> Very low energy |
| <input type="checkbox"/> Pain no better with rest | <input type="checkbox"/> Singing professionally | <input type="checkbox"/> Depression or anxiety | GENITOURINARY |
| <input type="checkbox"/> Feel lump in buttock | GASTROINTESTINAL | HEMATOLOGIC | <input type="checkbox"/> Swollen lymph glands |
| <input type="checkbox"/> Feel lump in abdomen | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Difficulty urinating |
| CARDIOVASCULAR | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Easy bruising/bleeding | <input type="checkbox"/> Burning on urination |
| <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Gums bleed easily | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Blood clots in legs | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Swollen ankles or feet | <input type="checkbox"/> Very dark or tar stool | <input type="checkbox"/> Blood clots in lungs | <input type="checkbox"/> Leaking urine |
| <input type="checkbox"/> Freq. night urination | <input type="checkbox"/> Ulcers | RHEUMATOLOGIC | WOMEN ONLY: |
| <input type="checkbox"/> Poor circulation | NEUROLOGIC | <input type="checkbox"/> Bad morning stiffness | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Short of breath if flat | <input type="checkbox"/> Burning pain | <input type="checkbox"/> Red or swollen joints | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Short of breath with exercise | <input type="checkbox"/> Shingles/herpes zoster | <input type="checkbox"/> Broken collarbone | <input type="checkbox"/> Breast lumps or discharge |
| | <input type="checkbox"/> Change of vision | <input type="checkbox"/> Rashes or skin changes | |

Have you ever had an infection with drug-resistant bacteria, e.g., methicillin-resistant staphylococcus (MRSA) or vancomycin-resistant enterococcus (VRE)? **YES / NO**

I. Family History (Check all that apply) ___NONE ___UNKNOWN

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Severe neck problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Alcohol dependence |
| <input type="checkbox"/> Severe back problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Mental illness |

J. Medications (List dose and schedule, write on back if needed) ___NONE

Any blood thinners (inc. aspirin)? **YES / NO**

Any cholesterol-lowering medicines? **YES / NO**

List: _____

List: _____

Any osteoporosis medicines? **YES / NO**

Are you taking calcium and vitamin D? **YES / NO**

List: _____

List: _____

OTHER: _____

K. Allergies to Medications ___NONE

Medication

Type of Reaction (i.e., what happens?)

Any allergy to latex or bananas? **YES / NO**

Any allergy to nickel or metals/jewelry? **YES / NO**

L. Social History:

1. Work status: ___Homemaker ___Student ___Working (list occupation): _____
___Retired ___Sick leave ___Not working
___On long-term disability or SSI ___Applying for long-term disability or SSI

2. Marital Status: ___Married ___Single ___Co-habiting
___Divorced ___Widowed

3. Number of living children: _____ Number of children living locally: _____

4. I live: ___Alone I live with: _____

5. Tobacco use: ___Never ___Cigarettes ___Cigars ___Pipe ___Chew
___Packs per day for _____years ___I QUIT using tobacco ___years ago

6. Alcohol use: ___Never ___# of drinks per day ___# of drinks per week
___Alcoholic (drunk daily) ___Recovering alcoholic

7. Drug use: ___Never ___Currently ___Past ___Former addict/rehab patient

8. Because of this problem, I HAVE FILED a: ___Lawsuit ___Workers' compensation claim

9. Because of this problem, I MAY / WILL FILE a: ___Lawsuit ___Workers' compensation claim

Patient Signature: _____ **Date:** _____

Pediatric and Adolescent Scoliosis/Kyphosis Questionnaire

Only fill out this form if you are seeing the doctor for SCOLIOSIS or KYPHOSIS.

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ HEIGHT: _____ ft. _____ in. WEIGHT: _____ lbs.

Approximate growth in last 6 months: _____

Height of mother: _____

Height of father: _____

Height of siblings: _____

Any relatives with scoliosis/kyphosis? _____

How was scoliosis/kyphosis discovered? _____

Previous treatment for scoliosis/kyphosis _____

Previous surgeons seen for condition: _____

Have you had your first menses/period? **YES / NO** Approximate start date? _____

Are your menses/periods regular? **YES / NO**

How old was your mother when her menses/periods began? _____

How do you feel about how: **0 1 2 3 4 5 6 7 8 9 10**
your spine looks? No problem Somewhat unhappy Very unhappy