****If you have had any imaging done (CT, X-ray, MRI etc.) please bring all images with you on a CD to your appointment**

The following questionnaire is a very important tool for our office to help assess your current condition and to help us determine the best course of treatment for you.

Please read and fill out all items in this form. Failure to completely fill this out and bring it with you to your appointment will result in a delay in your appointment.

Thank you very much for your cooperation and we look forward to working with you.

Contact Information

1. Name: _____Age: _____

2. Referring Physician:_____

Phone Number:_____ Fax Number:_____

Current Problem

3. State your reason for visit: _____

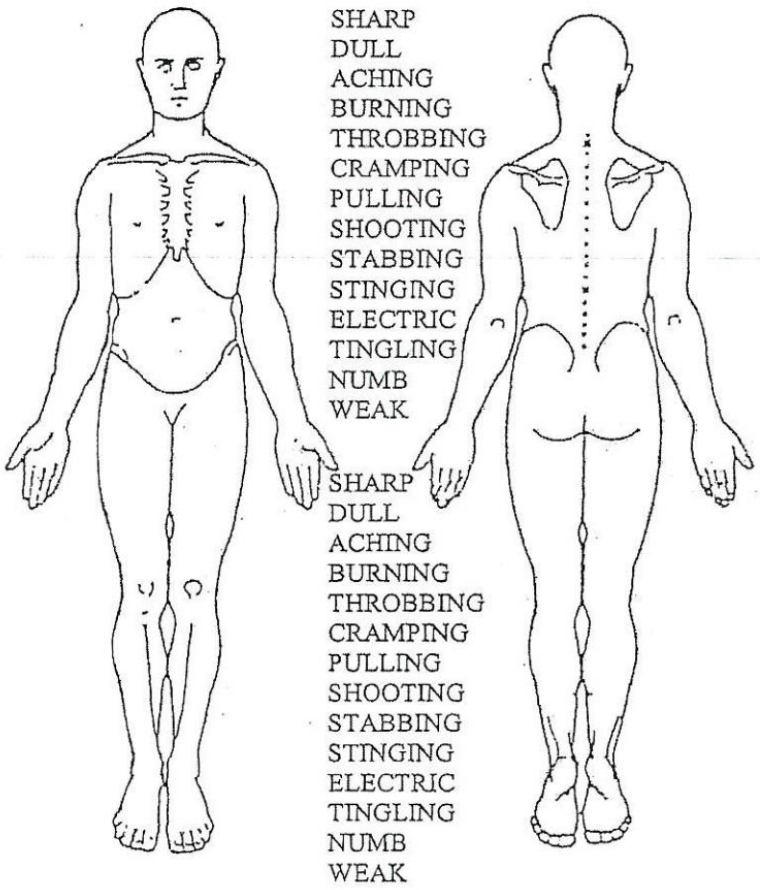
4. How long have you had these symptoms (days, months years)?
_____

5. When did these symptoms begin? (estimate) _____

Quality of Life

Sleep: Hours/Night _____ Do you: □ Have trouble falling asleep □ Have trouble staying asleep
□ Wake up because of pain □ Feel rested
Diet: □ Unrestricted □ Restrictions _____
Physical Activity/Exercise: _____
Work status: Are you currently working? _____
□ Full Duty □ Modified Duty □ Off work □ Unemployed Date Last Worked _____
Is your current problem due to an injury? □ Yes □ No Type? _____
If yes, is it work related? □ Yes □ No
If yes, please describe:

6. Do you have pain? If so, please use the drawing below to indicate its location and characteristics. **Shade** the areas of the diagrams below that correspond to your current pain, and **circle** any words that best describe your pain. You may **draw arrows** from the words to the areas they describe.



Pain Range (Best/Usual/Worst):
(please use a slash to mark each)

1	2	3	4	5	6	7	8	9	10

Over time, the problem is: ☐Better ☐Worse ☐Unchanged ☐Waxes and wanes ☐Tends to flare up
Any problems holding your urine? ☐Yes ☐No **Any problems holding your stool?** ☐Yes ☐No

What brings the pain on? ☐Sitting ☐Driving ☐Standing ☐Walking ☐Reaching ☐Bending
☐Twisting ☐Coughing/sneezing ☐Lying down ☐Other_____

What helps? ☐Rest ☐Sitting ☐Standing ☐Walking ☐Ice ☐Heat ☐Stretching ☐Lying down
☐Changing position ☐Other_____

Treatment and Medications

Name of medication or date of treatment — Helpful?

- Over-the-counter Medications _____ Yes/No
- Prescription Pain Medications _____ Yes/No
  - Current_____ Yes/No
  - Past_____ Yes/No
- Muscle Relaxants_____ Yes/No
- Physical Therapy_____ Yes/No
- Chiropractic Therapy_____ Yes/No
- Traction_____ Yes/No
- Braces_____ Yes/No
- Relaxation Training_____ Yes/No
- Hypnosis_____ Yes/No
- Biofeedback_____ Yes/No
- Ice/Heat_____ Yes/No
- Religious Counseling_____ Yes/No
- Psychological Counseling_____ Yes/No
- Surgery_____ Yes/No
- Massage_____ Yes/No
- Acupuncture_____ Yes/No
- Injections_____ Yes/No
  - Epidural Injections _____ Yes/No
  - Facet Injections_____ Yes/No
  - Peripheral Nerve Blocks _____ Yes/No
  - Sympathetic Block _____ Yes/No
  - Stellate Block _____ Yes/No
  - Trigger Point Injections _____ Yes/No
- TENS unit_____ Yes/No

Prior medications or treatments not listed above:

_____

_____

7. Any known problems with anesthesia? ☐Yes ☐No If you checked yes, please explain: _____
8. have you ever had a blood transfusion? ☐Yes ☐No If you checked yes, please explain: _____

9. Please let us know something about your previous spine surgery/surgeries: *Fill in as much as you can*

	What type of surgery was performed? (ALIF, PLIF, Lumbar Fusion, Scoliosis Surgery, Tumor Surgery, Laminectomy, Discectomy, ACDF, etc,)	Which Levels were Operated upon? (L45, L5S1, C6, C34, etc)	What was the date of the surgery?	Who was the Operating Physician?	Was a Fusion performed ?	Were there any complications?
#1						
#2						
#3						
#4						

Other spine surgeries/neurosurgeries or procedures related to why are seeing us today:

Name: _____ Date: _____

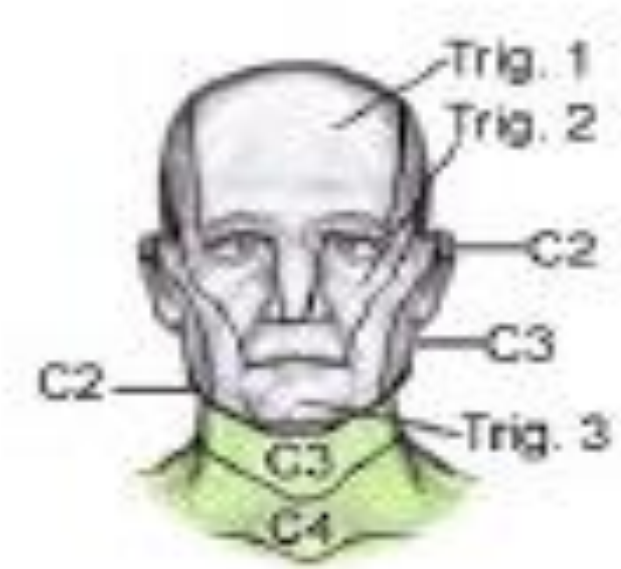
Name: _____ Date: _____

Name: _____ Date: _____

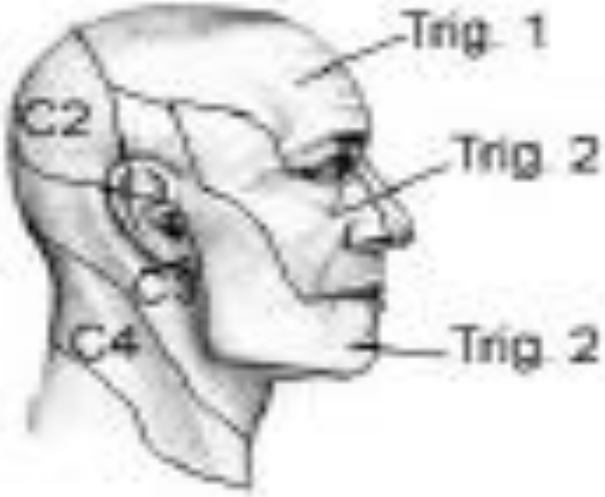
Name: _____ Date: _____

Substance use

Alcohol use ☐Yes ☐No # Times per week _____ # Glasses of wine/week: ____ # Cans/bottles of beer/week: ____ # Shots of liquor/week: ____ Total # of drinks/week: ____	Drug Use ☐Yes ☐No If you checked "yes", which type? Marijuana ☐Yes ☐No # Times per week _____ Cocaine ☐Yes ☐No # Times per week _____ Injectible Drugs ☐Yes ☐No # Times per week _____ Other ☐Yes ☐No # Times per week _____	Tobacco Use ☐Yes ☐No ☐Former # Packs/day: _____ # Packs/week: _____ # Years smoking: ____ Smokeless tobacco use? _____ Ready to quit? _____ Quit date _____


Trig. 1
Trig. 2
C2
C3
C2
Trig. 3
C3
C4


C2
C3
C4
C5
C6


Trig. 1
C2
Trig. 2
C4
Trig. 2