

University of Rochester Physicians Spine Center–New Patient History

Please answer all of the following questions in as much detail as possible. You may select more than one answer per question. Feel free to add additional information in the margins. Please note that each page is double-sided. This information will help in getting an accurate appraisal of your problems and develop an appropriate plan of treatment. If you have any questions or difficulty, please ask for assistance. **Thank you** for taking your time to fill this out completely.

What is your occupation? _____

What happened to cause your injury or pain?

What is your chief complaint?

- Neck Pain
- Upper Back Pain
- Lower Back Pain
- Right Leg Pain
- Left Leg Pain
- Pain in Both Legs
- Right Arm Pain
- Left Arm Pain
- Pain in Both Arms
- Scoliosis
- Other - Specify _____

How did the injury occur?

- None/Spontaneous Onset
- Motor Vehicle Accident - No Lawsuit
- Motor Vehicle Accident - Lawsuit Pending
- Motor Vehicle Accident - Lawsuit Complete
- Fall
- Sports or Recreation
- Job Related
- Other – Specify _____

Was the injury job related?

- Yes
- No

If motor vehicle accident, were you?

- Driver
- Front Seat Passenger
- Rear Seat Passenger
- Motorcycle Driver
- Motorcycle Passenger
- Truck Driver
- Truck Passenger
- Other – Specify _____

Were you wearing a seatbelt?

- Yes
- No

Other injuries:

- Head
- Chest
- Extremities, Fracture
- Extremities, No Fracture
- Abdominal
- Other – Specify _____
- None

Did the pain start immediately or was there a delayed onset?

- Immediate
- Delayed 1-4 days
- Delayed 1-2 weeks
- Delayed 2-4 weeks
- Delayed 4-8 weeks

When did the pain start? _____
Month/Day/Year

Since the pain/condition began has it:

- Improved
- Not changed
- Continued to come and go
- Worsened

Do you participate in sports or athletics?

- Regularly 3x/week
- Regularly 2x/week
- Regularly 1x/week
- Irregularly
- None
- Medical Problems Prevent

What aggravates the pain?


- Walking
- Standing
- Sitting
- Lying down
- Bending Forward
- Bending Backwards
- Twisting
- Lifting
- Nothing in particular

What makes the pain better?

- Sitting
- Lying down
- Walking
- Standing
- Leaning Forward or a Shopping Cart
- Nothing in particular

Check all that apply, then

- nothing
- Physical therapy
- active exercise
- TENS unit
- heat
- cold
- manipulation
- Spinal injections
- surgery
- pain psychology
- holistic or alternative treatments
- Chiropractor
- Medication
- Other – Specify _____

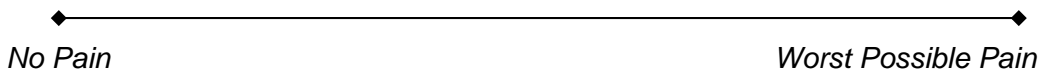
 **Please circle any of these that were helpful in relieving your pain (or circle 'nothing').**

The following lines represent pain of increasing intensity from “no pain” to “very severe pain.” Draw ONE vertical mark on each of the lines below to best describe:

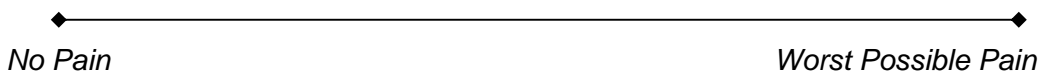
Your pain right now:



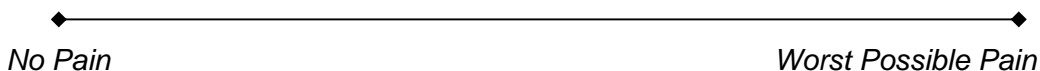
The average intensity of your pain this week:



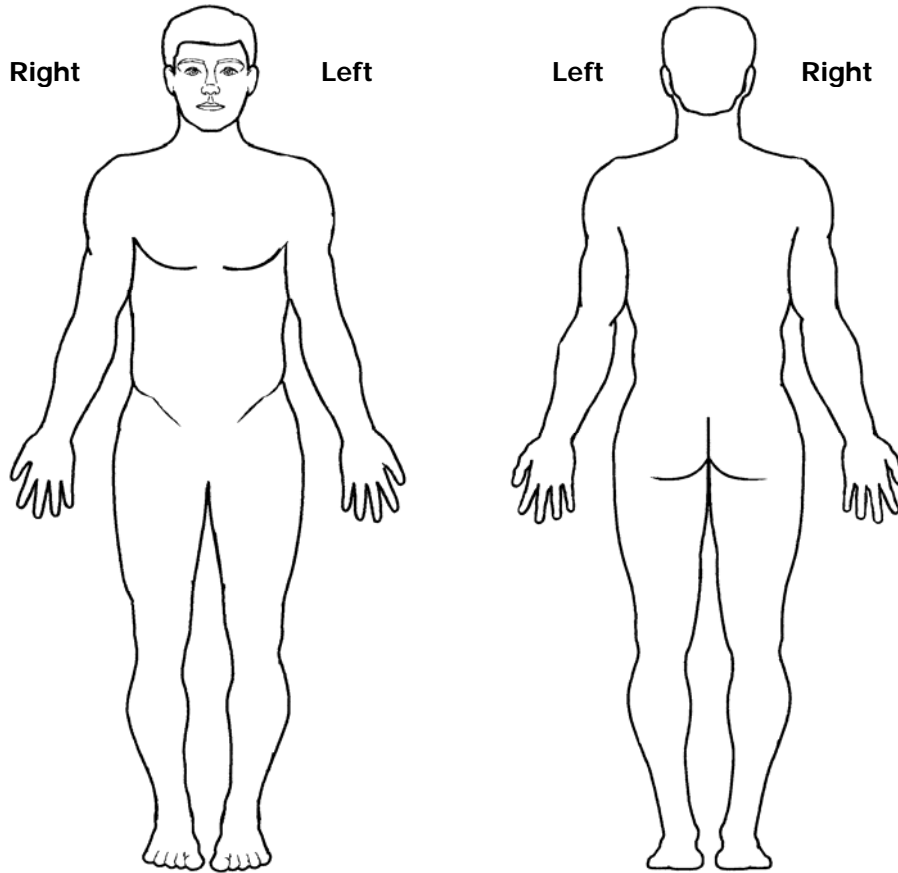
Your pain at its worst:



Your pain at its least:



On the drawings below, please shade the area where you currently experience pain.



The following questions are about activities you might do during a typical day. Does your back problem now limit you in these activities? If so, how much? Check only one answer for each activity.

	No, not limited at all	Yes, limited a little	Yes, limited a lot
Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports	[]	[]	[]
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[]	[]	[]
Lifting or carrying groceries	[]	[]	[]
Climbing several flights of stairs	[]	[]	[]
Climbing one flight of stairs	[]	[]	[]
Bending, kneeling, or stooping	[]	[]	[]
Walking more than one mile	[]	[]	[]
Walking several blocks	[]	[]	[]
Walking one block	[]	[]	[]
Bathing or dressing yourself	[]	[]	[]

Choose one response option for each activity.

	Not difficult at all	Minimally Difficult	Somewhat difficult	Fairly difficult	Very Difficult	Unable to do
Turn over in bed	[]	[]	[]	[]	[]	[]
Ride in a car	[]	[]	[]	[]	[]	[]
Sit in a chair for several hours	[]	[]	[]	[]	[]	[]
Lift and carry a heavy suitcase	[]	[]	[]	[]	[]	[]

The following questions are designed to give the doctor information as to how your spine(back) pain has affected your ability to manage in everyday life. **Please answer every section, and choose only the one box that applies to you.** Sometimes two of the statements in one section seem right, but please just mark the box that most closely describes your problem.

Section 1 – Pain Intensity (choose only one)

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I manage without painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on pain and I don't use them.

Section 2 – Personal Care (choose only one)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes me extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting (choose only one)

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking (choose only one)

- Pain does not prevent me walking any distance.
- Pain prevents me from walking for more than 1 mile.
- Pain prevents me from walking for more than ½ mile.
- Pain prevents me from walking for more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting (choose only one)

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing (choose only one)

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping (choose only one)

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets, I have less than 6 hours sleep.
- Even when I take tablets, I have less than 4 hours sleep.
- Even when I take tablets, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex Life (choose only one)

- My sex life is normal and causes no extra pain.
- My sex life is normal, but causes some extra pain.
- My sex life is nearly normal, but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life (choose only one)

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 10 – Traveling (choose only one)

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over two hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to journeys of less than 30 minutes.
- Pain prevents me from traveling, except to the doctor or hospital.

Do you have any problems with bowel, bladder, or sexual functions?

- None
- No problems except for occasional constipation
- Difficulty controlling bladder functions
- History of urinary tract infections
- Sexual problems secondary to pain
- Physical problems with sexual function other than pain
- Other - Specify _____

Do you have any difficulty walking?

- No
- Yes, can walk less than a mile
- Yes, can walk only 1-2 blocks
- Yes, can walk unlimited distance
- Yes, non-ambulatory

Are you right or left handed?

- Right handed
- Left handed
- Ambidextrous

Are you:

- married
- single
- divorced
- widow/widower
- separated
- other _____

With whom do you live?

- living with spouse
- living alone
- living with children
- living with parents
- living in a community
- other _____

What is the highest grade you completed or degree you received? _____

What is your current work status?

- Regular Employment - No Restrictions
- Full - Time with Restrictions
- Part - Time by Choice
- Part - Time for Medical Reasons
- Retired by Choice
- Retired by Medical Reasons
- Unemployed - Looking for work with no restrictions
- Unemployed - Looking for light duty
- Unemployed
- Currently not working for medical reasons
- Student
- Other – Specify _____

Have you attempted to return to work since the onset of your pain?

- Yes – When did you attempt this return? _____
- No
- This does not apply to me.

When did you last work? _____

Please mark all of the following that apply to you.

<p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low fever <input type="checkbox"/> High fever <input type="checkbox"/> Chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Unusual tiredness <input type="checkbox"/> Insomnia <input type="checkbox"/> Sedation <p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> abnormal vision <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses <p>Ears, Nose, Mouth, Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> ringing in ears <input type="checkbox"/> room spinning <input type="checkbox"/> dizziness <input type="checkbox"/> sinus pain <input type="checkbox"/> sinus drainage <input type="checkbox"/> mouth sores <input type="checkbox"/> sore throat <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> high blood pressure <input type="checkbox"/> angina (chest pain) <input type="checkbox"/> trouble breathing <input type="checkbox"/> trouble breathing when flat <input type="checkbox"/> ankle swelling <input type="checkbox"/> heart attack <input type="checkbox"/> congestive heart failure <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> abnormal heart rhythm <input type="checkbox"/> heart murmur <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> heavy cough <input type="checkbox"/> cough up sputum <input type="checkbox"/> cough up blood <input type="checkbox"/> pneumonia <input type="checkbox"/> asthma <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> fainting <input type="checkbox"/> epilepsy (seizures) <input type="checkbox"/> stroke <input type="checkbox"/> memory problems 	<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> nausea <input type="checkbox"/> stomach pain <input type="checkbox"/> vomiting <input type="checkbox"/> vomiting blood <input type="checkbox"/> vomiting "coffee grounds" <input type="checkbox"/> ulcers <input type="checkbox"/> hiatal hernia <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> change in bowel habits <input type="checkbox"/> blood in stool <input type="checkbox"/> black, tarry stools <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> painful urination <input type="checkbox"/> blood in urine <input type="checkbox"/> vaginal discharge <input type="checkbox"/> discharge from penis <input type="checkbox"/> impotence <input type="checkbox"/> loss of sexual desire <input type="checkbox"/> painful sex <input type="checkbox"/> kidney problems <input type="checkbox"/> one kidney <input type="checkbox"/> kidney failure <input type="checkbox"/> dialysis <input type="checkbox"/> kidney transplant <input type="checkbox"/> venereal disease <input type="checkbox"/> change in bladder habits <input type="checkbox"/> urgency <input type="checkbox"/> hesitancy <p>Date of last menstrual period: _____</p> <p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> painful joints <input type="checkbox"/> swollen joints <input type="checkbox"/> redness of joints <input type="checkbox"/> joint infection <input type="checkbox"/> bone infection <input type="checkbox"/> gout <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> ankylosing spondylitis <input type="checkbox"/> osteoporosis <input type="checkbox"/> osteomalacia <input type="checkbox"/> sore muscles <input type="checkbox"/> muscle spasms <p>Integumentary (Skin)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin Sores <input type="checkbox"/> Skin Rash <input type="checkbox"/> Itching <input type="checkbox"/> Skin Cancer 	<p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> depression <input type="checkbox"/> want to die <input type="checkbox"/> anxiety <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid (too little) <input type="checkbox"/> thyroid (too much) <p>Hematologic/Lymphatic</p> <ul style="list-style-type: none"> <input type="checkbox"/> unusual sweating <input type="checkbox"/> unusual bleeding <input type="checkbox"/> easy bruising <input type="checkbox"/> mass (lumps or bumps) <input type="checkbox"/> breast lump <input type="checkbox"/> swollen glands <input type="checkbox"/> anemia <input type="checkbox"/> infection <input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> hepatitis <input type="checkbox"/> cancer _____ <i>what type?</i> <p>Other Medical Problems:</p> <p>Do any of your blood relatives have any of these diseases?</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Back or Neck Problems <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> high blood pressure <input type="checkbox"/> lung problems <input type="checkbox"/> diabetes <input type="checkbox"/> kidney problems <input type="checkbox"/> ulcers <input type="checkbox"/> heart problems <input type="checkbox"/> gout <input type="checkbox"/> epilepsy (seizures) <input type="checkbox"/> stroke <input type="checkbox"/> thyroid (too little) <input type="checkbox"/> thyroid (too much) <input type="checkbox"/> anemia <input type="checkbox"/> Other – Specify _____
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Have you ever had other episodes or injuries with your neck or back?

- No, never
- Yes, one → This episode or injury was in _____ (year).
- Yes, more than one → The first episode or injury was in _____ (year).
 The last episode or injury was in _____ (year).
 Total number of episodes or injuries: _____.
 Frequency of these episodes or injuries:
 - more than once a week
 - once a week
 - once a month
 - once a quarter (every three months)
 - once a year
 - less than once a year

Have you ever been involved in any legal proceedings related to **this** health matter?

- No
- Yes
 - disability or social security
 - workman's compensation
 - a motor vehicle crash
 - medical malpractice
 - other legal proceedings, *please describe*: _____

Have you ever been involved in any legal proceedings related to a **previous** health matter?

- No
- Yes
 - disability or social security
 - workman's compensation
 - a motor vehicle crash
 - medical malpractice
 - other legal proceedings, *please describe*: _____

Have you had any previous neck or back(**spine**) surgery?

- | | |
|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Yes, one | <input type="checkbox"/> Yes, six |
| <input type="checkbox"/> Yes, two | <input type="checkbox"/> Yes, seven |
| <input type="checkbox"/> Yes, three | <input type="checkbox"/> Yes, eight |
| <input type="checkbox"/> Yes, four | <input type="checkbox"/> Yes, nine |
| <input type="checkbox"/> Yes, five | <input type="checkbox"/> No |

Please list your previous neck and back(**spine**) operations:

Date:	Place:	Surgeon:	Procedure:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What surgery have you had **other than spine or back surgery?**

Date: _____ Place: _____ Surgeon: _____ Procedure: _____

Have you had any of the following complications of surgery?

- Bleeding
- Infection
- Poor Wound Healing
- Other – Specify _____

Thank you for completing this questionnaire!

<u>FOR OFFICE USE ONLY</u>	
Height: _____	INCHES Weight: _____
BP: _____ / _____	Pulse: _____ Respiration: _____

Revised 09/04