



COMPREHENSIVE SPINE CENTER

A COLLABORATION OF MIDWEST ORTHOPAEDIC CENTER AND METHODIST MEDICAL CENTER



COMPREHENSIVE SPINE CENTER QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS: Referring Physician: _____ Family Doctor : _____

Name _____ DOB _____ SS# _____

Home phone _____ Cell Phone _____ Gender: _____ Male _____ Female

Weight: _____ Height: _____ Are you allergic to latex ? yes _____ no _____ Contrast dye? yes _____ no _____

ALLERGIES: _____

Name/Location of Preferred Pharmacy _____ Phone # _____

Friend Relative Contact _____ Phone _____

SOCIAL HISTORY:

Marital Status: Married _____ Single _____ Partnered _____ Separated _____ Divorced _____ Widowed _____

Number of Living Children _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

I Live : _____ Alone _____ With: _____

Years of Formal Education _____ Are you currently employed? YES _____ NO _____

Work Status: _____Homemaker _____Retired _____Disabled _____On leave _____Unemployed
_____Working: full time _____ part time _____

Date of last employment _____ Occupation _____

Have you been declared disabled? YES _____NO _____ Are you applying for disability ? YES _____ NO _____

Because of this spine problem, I have filed or plan to file:

_____ a lawsuit _____ a worker's compensation claim _____ neither a lawsuit or a worker's compensation claim

For office use only:

Reviewed by nurse: _____ initials _____ date: _____

PATIENT STICKER



COMPREHENSIVE SPINE CENTER QUESTIONNAIRE

Chart Forms 7750.044 (04-30-08) PAGE 1 OF 7 *2DTQ*



Tobacco use: Never (skip to next question)

Cigar Chew Pipe Cigarettes: packs per day for years.

Quit: When? after smoking packs per day for years. (total)

Alcohol: Never or Rare Social Frequently drunk (more than twice per week)

Alcoholic Recovering Alcoholic

Drug Overuse/Abuse: Never Currently In the past

ABUSE ASSESSMENT SCREEN:

Have you felt unsafe where you have been living? yes no

If yes, explain _____

Have you been emotionally, physically or sexually hurt by someone? yes no

Do you have a living will? copy provided?

Do you have durable power of attorney for your healthcare? yes no

Please list those people that you are providing permission for us to communicate with when necessary?

Please remember, this does not include decision-making. Only a healthcare power of attorney designee can perform that function.

Patient signature: _____

MEDICAL HISTORY:

Check any of the following that you have had in the past.

Childhood Illnesses

measles mumps chicken pox rubella roseola scarlet fever polio



General

weight loss fever/chills night sweats loss of appetite dizziness seizures anemia

headaches bruising cancer diabetes tuberculosis rheumatic fever heart disease

multiple sclerosis hepatitis thyroid illness HIV / AIDS



PATIENT STICKER



COMPREHENSIVE SPINE CENTER QUESTIONNAIRE

Chart Forms 7750.044 (04-30-08) PAGE 2 OF 7 *2DTQ*



Cardiovascular

___ heart attack ___ chest pain ___ high blood pressure ___ irregular heart beats ___ pacemaker
___ coronary artery disease ___ poor circulation ___ stroke ___ swelling of hands or feet ___ heart surgery

Gastrointestinal

___ bowel changes ___ loss of appetite ___ constipation ___ indigestion ___ nausea ___ pancreatitis
___ hepatitis ___ stomach ulcers ___ gastro-esophageal reflux ___ appendicitis ___ cholecystitis
___ cancer of esophagus/stomach/intestines ___ bleeding of esophagus/stomach/intestines /rectum

Respiratory

___ asthma ___ pneumonia ___ bronchitis ___ emphysema/COPD ___ tuberculosis ___ asbestosis
___ cancer of the lung ___ surgery involving the lung

Genito-urinary

___ blood in urine ___ difficulty urinating ___ incontinent of urine ___ frequent urination ___ painful urination
___ sexually transmitted disease ___ cancer of the kidney / bladder / urinary organs

Eye, ear, nose, throat

___ blurred vision ___ cataracts ___ glaucoma ___ visual disturbance ___ loss of vision ___ bleeding gums
___ tonsillitis ___ persistent cough ___ sinus problems ___ earaches ___ ringing in ears ___ nose bleeds ___ gum disease

Psych

___ depression ___ anxiety ___ sleep problems ___ nervousness ___ eating disorder ___ psychiatric illness
___ suicide attempt ___ psychiatric hospitalizations

Have you been treated with steroid medications by injection or in pill form in the last year?

Explain: _____

PATIENT STICKER





TESTING TO EVALUATE PROBLEMS: none

Test	Neck/Back	#1 Date/Where	#2 Date/Where	#3 Date/Where
Plain x-rays				
Myelogram				
CT Scan				
MRI				
EMGs				
Bone Scan				
FCE				
Vascular Studies				
DEXA Scan				
Discogram				

PREVIOUS TREATMENTS:

Type of treatment	Date	Facility	Doctor

FUNCTIONAL ASSESSMENT:

Have you had any recent changes in your life that could affect your coping abilities? yes no
If yes, explain (job change, move, divorce, family death etc.)

Are you able to care for yourself without the assistance of others? yes no

Do you have any social, cultural, religious beliefs or values that may affect your treatment plan or healthcare needs?

PATIENT PAIN ASSESSMENT:

Describe primary pain problems for which you are seeking help.

Are you experiencing pain anywhere else?

PATIENT STICKER



When did the primary pain problem start? _____



Is your pain due to a work-related accident or injury? _____

Please rate your pain anywhere along the scale. 0 = none 10 = worst pain imaginable

When pain is at its worst.

0 _____ 10

When pain is at its best or well controlled.

0 _____ 10

Please indicate anywhere along the scale how much this pain interferes with your ability to perform normal daily activity.

0 = not at all 10= unable to perform

0 _____ 10

Time of day pain is best. _____ worst _____

What eases, decreases or reduces your pain? _____

PATIENT PAIN ASSESSMENT, CONTINUED

Is your pain constant or does it “ come and go “? _____

Check description of your pain. ___ Burning ___ Aching ___ Stabbing ___ Throbbing ___ Shooting

Does your pain cause you to have trouble sleeping? _____

FALL ASSESSMENT:

Do you require any assistive devices? ___yes ___no

___wheelchair ___walker ___cane ___crutches ___joint brace

History of recent falls? ___yes ___no If yes, date(s) _____

PATIENT STICKER



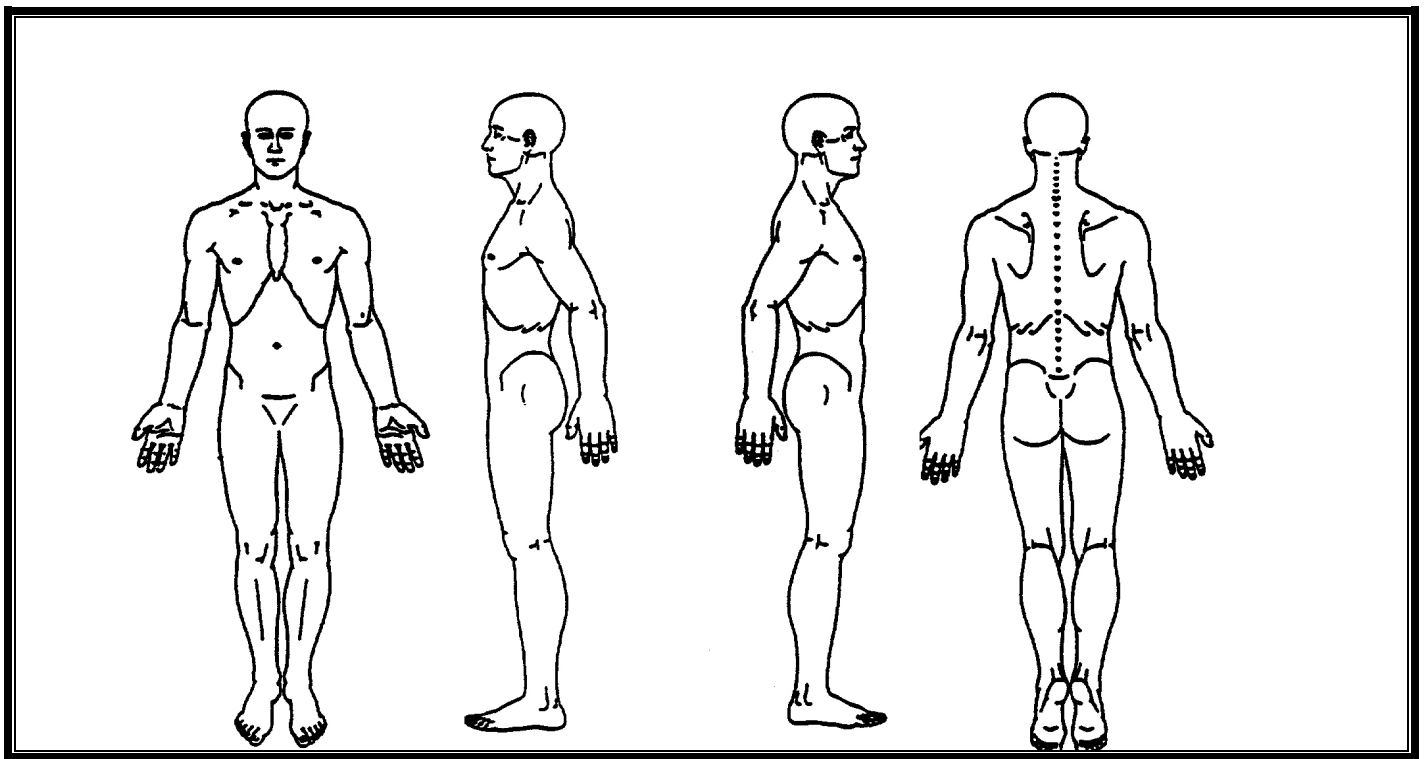
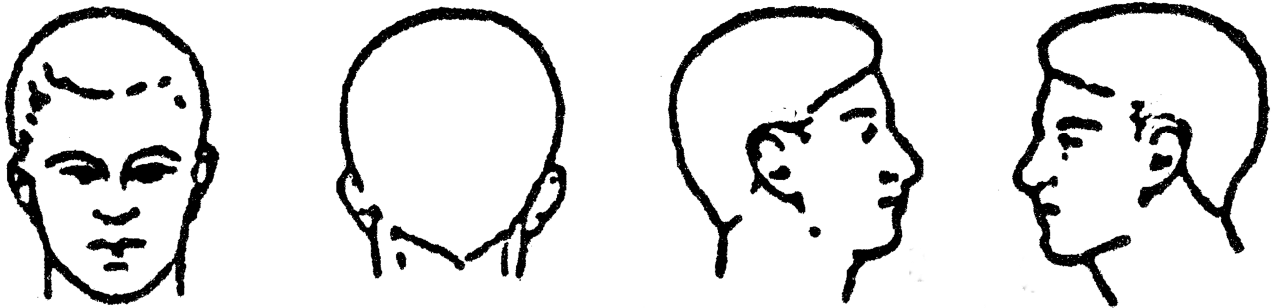
COMPREHENSIVE SPINE CENTER QUESTIONNAIRE

Chart Forms 7750.044 (04-30-08) PAGE 6 OF 7 *2DTQ*

PAIN DIAGRAM: Please mark figures below, indicating the locations of your pain.

Burning = xxx
Pins / Needles = +++
Numbness = NNN

Dull / Aching = >>>>
Sharp / Cutting = /////
Cramping = SSS



Patient Signature (or person completing form) _____ DATE _____

Relationship to patient _____

PATIENT STICKER



COMPREHENSIVE SPINE CENTER QUESTIONNAIRE

Chart Forms 7750.044 (04-30-08) PAGE 7 OF 7 *2DTQ*