

# SPINE QUESTIONNAIRE

Colorado Comprehensive Spine Institute

Date: \_\_\_\_\_

Male

Female

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

If not referred by a doctor, how did you hear about us? \_\_\_\_\_

## HISTORY OF PRESENT COMPLAINT

Where is your problem located?  Neck  Upper Back  Arm  Lower Back  Hip  Leg

How long have you had this problem? \_\_\_\_\_ Since? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

Briefly, please describe the onset of your current back/neck pain and the events preceding your pain:

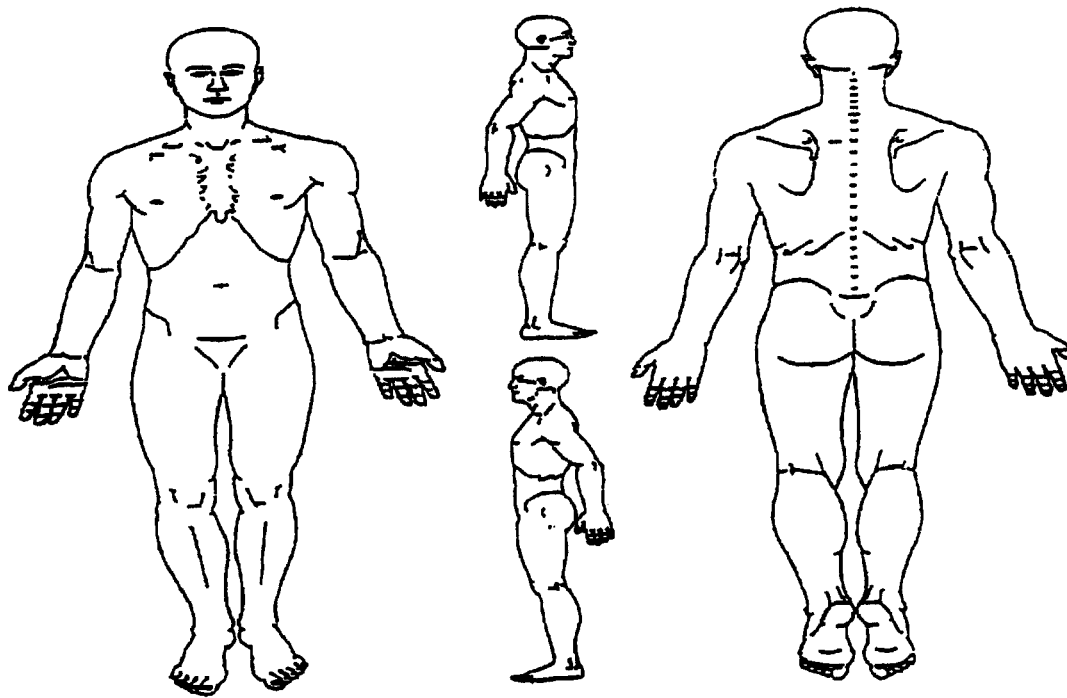
Was this from a work-related injury?  NO  Yes Is it under Workers' Compensation?  NO  YES

Have you missed any work because of this problem?  NO  YES, how much? \_\_\_\_\_

Was this from an auto injury?  NO  YES

Please indicate where you have pain by marking the areas on your body where you have the described sensations. Use the appropriate symbol:

ACHE >>>>      NUMBNESS ----      PINS &      0000      BURNING XXX      STABBING ///  
>>>>                ----      NEEDLES 0000                XXX                ///



**PAIN SCALE**

**Circle a number to indicate the level of your pain for the current injury in the situations listed below:**

	<b>None</b>										<b>Severe</b>
<b>PAIN TODAY</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>GREATEST PAIN</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>PAIN AT REST</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>

Which of the following activities change the nature of your pain?

	<b>Aggravates Pain</b>	<b>Relieves Pain</b>	<b>Neither</b>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from Seated Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing/Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one):

- A. My symptoms have remained the same since the time of onset.
- B. My symptoms are more severe since the time of onset.
- C. My symptoms are less severe since the time of onset.

**FOR CLINICAL USE ONLY**

Height _____	Weight _____	Comments: _____ _____ _____ _____
Pulse _____	Resp. _____	
Temp. _____	B.P. _____	

**PAST BACK/NECK HISTORY**

Of the following treatments, please indicate the effect of those which have been used in an attempt to help your present injury:

	<b>Helpful</b>	<b>No Help</b>	<b>Not Used</b>
Anti-inflammatories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bracing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet Block/Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI Joint Block/Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction/ VAS-D (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicate whether you have had any of the following studies and when/where the most recent was performed:

	<b>YES</b>	<b>NO</b>	<b>WHEN/WHERE</b>		<b>YES</b>	<b>NO</b>	<b>WHEN/WHERE</b>
Regular X-ray of Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan of Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI of the Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____	EMG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Have you had past episodes of similar pain or injury?       NO                       YES, Please Describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**CURRENT MEDICATIONS****ALLERGIES**

NAME	DOSE		NAME	REACTION

(Please attach an additional sheet if necessary)

**FAMILY HISTORY****What illnesses run in your close family?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> No medical problems | <input type="checkbox"/> Scoliosis     | <input type="checkbox"/> Spine disease       |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Bleeding disorder   |
| <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Kidney disease      |
| <input type="checkbox"/> Other: _____        |  |  |
| <input type="checkbox"/> Other: _____        |  |  |

**SOCIAL HISTORY**

Current work status:     Working full duty     Working restricted duty (since \_\_\_\_\_)     Retired  
 Disabled (since \_\_\_\_\_)     Student     Homemaker     Unemployed

Company: \_\_\_\_\_ Occupation: \_\_\_\_\_ Title: \_\_\_\_\_

Marital Status:     Single     Married     Divorced     Widowed     Other \_\_\_\_\_

Number of Children: \_\_\_\_\_

Are you a cigarette smoker?     Yes, currently     Never     Quit, In what year did you quit? \_\_\_\_\_

If you answered "yes" or "quit," how much do or did you smoke per day?

Less than 1/2 pack     1/2 pack     3/4 pack     1 pack     2 packs     More ( how many?) \_\_\_\_\_

How old were you when you started smoking? \_\_\_\_\_

Do you drink any alcoholic beverages? (check one)

None     0 to 3 drinks per month     1 to 2 drinks per week     1 to 2 drinks per day     3 to 5 drinks per day  
 More than 5 drinks per day (how many?) \_\_\_\_\_

Have you ever had a problem with drug dependence?     YES     NO

**REVIEW OF SYSTEMS**

GENERAL

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night sweats
- Marked fatigue
- Difficulty Sleeping

EAR, NOSE, THROAT

- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds
- Gum trouble

EYES

- Glasses
- Change in vision

CARDIOVASCULAR

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

LUNG

- Morning cough
- Shortness of breath
- Productive cough or sputum

DIGESTIVE

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn/acid stomach
- Frequent diarrhea
- Frequent constipation
- Uncontrolled loss of stool
- Blood in stool
- Hemorrhoids

SKIN

- Frequent rashes
- Frequent itchiness
- Easy bruising
- Swollen ankles

NEUROLOGICAL

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines

MUSCULOSKELETAL

- Joint pain/swelling
- Back pain
- Neck pain
- Muscle aches

GENITOURINARY

- Burning on urination
- Difficulty starting urination
- Incontinence
- Pelvic pain
- Urinate

PSYCHIATRIC

- Depression
- Nervous exhaustion
- Anxiety
- Paranoia
- Obsessive/compulsive behavior

**The information I have provided is true and complete to the best of my knowledge.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENT INFORMATION**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Name Middle Initial Last Name Date of Birth M / F  
Sex (circle one)

\_\_\_\_\_  
Street Address City State Zip Code

(\_\_\_\_\_) (\_\_\_\_\_)  
Home Phone Work/Cell Phone Social Security Number Marital Status

(\_\_\_\_\_) (\_\_\_\_\_)  
Referring Physician Phone Number Primary Care Physician Phone Number

(\_\_\_\_\_) (\_\_\_\_\_)  
Name of Nearest Relative Not Living With You Relationship Home Phone Work/Cell Phone

**INDIVIDUAL RESPONSIBLE FOR PAYMENT**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Name Middle Initial Last Name Date of Birth M / F  
Sex (circle one)

\_\_\_\_\_  
Street Address City State Zip Code

(\_\_\_\_\_) (\_\_\_\_\_)  
Home Phone Work/Cell Phone Social Security Number Relationship to Patient

\_\_\_\_\_  
Employer Employer Address

**INSURANCE INFORMATION**

\_\_\_\_\_  
Primary Insurance Company Name

\_\_\_\_\_  
Secondary Insurance Company Name

\_\_\_\_\_  
Insurance Address

\_\_\_\_\_  
Insurance Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Policy ID # Group #

\_\_\_\_\_  
Policy ID # Group #

\_\_\_\_\_  
Name of Policy Holder Relationship to Insured

\_\_\_\_\_  
Name of Policy Holder Relationship to Insured

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Policy Holder Date of Birth Policy Holder SSN

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Policy Holder Date of Birth Policy Holder SSN

**ASSIGNMENT OF BENEFITS AND IN/OUT OF NETWORK ACKNOWLEDGEMENT**

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance company be paid directly to the provider. I also authorize my providers' office to release to my insurance company any and all information necessary for the processing of insurance claims. I acknowledge that some Colorado Comprehensive Spine Institute, LLC providers MAY NOT be in network with my insurance and I may be responsible for in and out of network deductibles and/or co-insurance. I understand that I am responsible for reasonable attorney fees and courts costs if placed into collection.

SIGNATURE (REQUIRED) \_\_\_\_\_ DATE \_\_\_\_\_