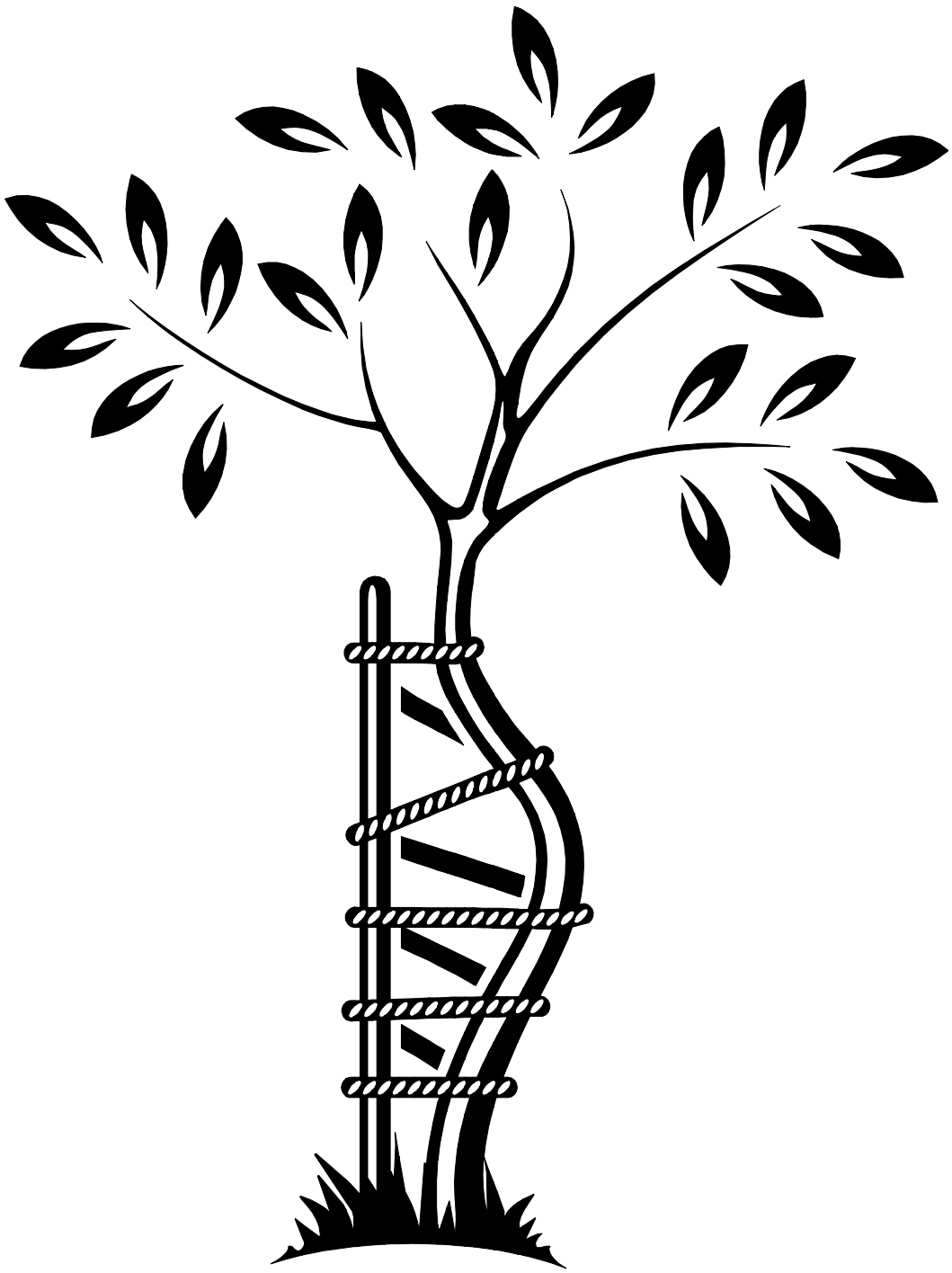
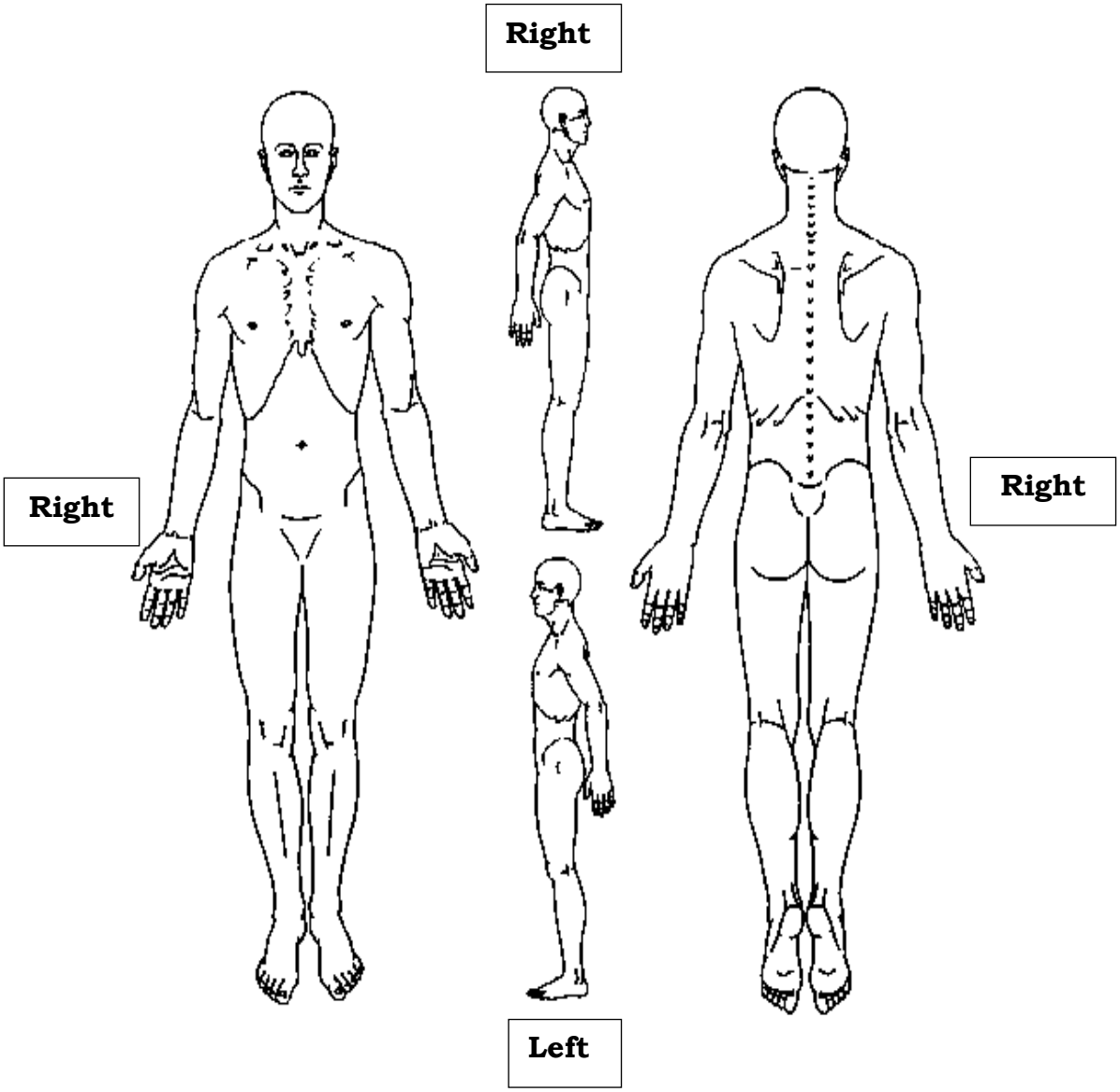
Thoracic and Lumbar Spine

New Patient Form



Please mark the painful areas on the pictures below



Use the following:

•••• stabbing pain OOO burning pain +++ aching pain

□□□ pins and needles === numbness

New Patient Questionnaire

Date _____

Name _____

Referred by _____

Age _____ Date of Birth _____

Gender: _____

Major complaint

Enter the percentage of pain (from 1% to 100%) for each problem **(the sum should be 100%!)**

Pain in:

Back: _____ %

Left Leg: _____% Left Buttock: _____% Left Foot: _____%

Right Leg: _____% Right Buttock: _____% Right Foot: _____%

Mark the degree of pain with an X on the lines below

(Indicate the **least** and the **worst** pain, as well as the **average** amount of pain)

Back

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Legs

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Buttocks

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

Feet

0 (less pain) ----------3----------5----------7----------▶ 10 (more pain)

When did symptoms start? _____

How did symptoms start? _____

_____

_____

Do you feel any numbness? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

Do you feel any tingling? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

Do you have any weakness? ❑ Left arm ❑ Right arm ❑ Left leg ❑ Right leg

I have tried:

1. ❑ Physiotherapy Helpful? ❑ Yes ❑ No
2. ❑ Stretching Helpful? ❑ Yes ❑ No
3. ❑ Exercises Helpful? ❑ Yes ❑ No
4. ❑ Acupuncture Helpful? ❑ Yes ❑ No
5. ❑ Chiropractors Helpful? ❑ Yes ❑ No
6. ❑ TENS Unit Helpful? ❑ Yes ❑ No
7. ❑ Epidural/facet injection Helpful? ❑ Yes ❑ No
8. ❑ Traction Helpful? ❑ Yes ❑ No
9. ❑ Medications Helpful? ❑ Yes ❑ No

My symptoms are relieved by:

1. ❑ Sitting
2. ❑ Standing
3. ❑ Walking
4. ❑ Lying on my side
5. ❑ Lying on my back
6. ❑ Lying on my stomach
7. ❑ Bending forward
8. ❑ Bending backward

My symptoms are worsened by:

1. ❑ Sitting
2. ❑ Standing
3. ❑ Walking
4. ❑ Lying on my side
5. ❑ Lying on my back
6. ❑ Lying on my stomach
7. ❑ Bending forward
8. ❑ Bending backward

How long can you do the following without pain?

Sit	____ minutes	____ hours	❑ no restrictions
Stand	____ minutes	____ hours	❑ no restrictions
Walk	____ minutes	____ hours	❑ no restrictions

What tests have been done on your back in the last year:

❑ (1) Regular X-rays ❑ (2) MRI ❑ (3) CT Scan ❑ (4) Myelogram

❑ (5) EMG ❑ (6) Discogram ❑ (7) CT Myelogram ❑ (8) Neurogram

❑ (9) Bone density study

Oswestry Questionnaire

Please circle one best answer per section!

SECTION 1 - Pain Intensity

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

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

SECTION 3 - Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it gives extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

SECTION 4 - Walking

1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than 1/4 mile.
4. Pain prevents me from walking more than 100 yards.
5. I can only walk while using a stick or crutches.
6. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

1. I can sit in any chair as long as I like.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than 1 hour.
4. Pain prevents me from sitting more than 1/2 hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

SECTION 6 - Standing

1. I can stand as long as I want without extra pain.
2. I can stand as long as I want but it gives me extra pain.
3. Pain prevents me from standing for more than 1 hour
4. Pain prevents me from standing more than 30 min.
5. Pain prevents me from standing for more than 10 min.
6. Pain prevents me from standing at all.

SECTION 7 - Sleeping

1. My sleep is never disturbed by pain.
2. My sleep is occasionally disturbed by pain.
3. Because of pain I have less than 6 hours' sleep.
4. Because of pain I have less than 4 hours' sleep.
5. Because of pain I have less than 2 hours' sleep.
6. Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)

1. My sex life is normal and causes me no extra pain.
2. My sex life is normal, but causes some extra pain.
3. My sex life is nearly normal but is very painful.
4. My sex life is severely restricted by pain.
5. My sex life is nearly absent because of pain.
6. Pain prevents any sex life at all.

SECTION 9 - Social Life

1. My social life is normal and causes me no extra pain.
2. My social life is normal, but increases the degree of pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests
4. Pain has restricted my social life and I do not go out as often.
5. Pain has restricted my social life to my home.
6. I have no social life because of the pain.

SECTION 10 - Traveling

1. I can travel anywhere without pain.
2. I can travel anywhere but it gives extra pain.
3. Pain is bad but I manage journeys over 2 hours.
4. Pain restricts me to journeys of less than 1 hour.
5. Pain restricts me to short journeys under 30 min.
6. Pain prevents me from traveling

Review of Systems

In the past month I have had (Mark anything that applies):

General

1. ❑ Fever
2. ❑ Chills
3. ❑ Unexplained weight loss
4. ❑ Night sweats
5. ❑ Fatigue
6. ❑ Loss of appetite

Neurological

7. ❑ Numbness
8. ❑ Dizziness
9. ❑ Tingling
10. ❑ Tremors
11. ❑ Dyscoordination
12. ❑ Migraines
13. ❑ Headaches
14. ❑ Memory problems

Musculoskeletal

15. ❑ Joint pain
16. ❑ Joint stiffness
17. ❑ Joint swelling
18. ❑ Joint redness

Pulmonary

19. ❑ Cough
20. ❑ Shortness of breath
21. ❑ Wheezing

Cardiac

22. ❑ Chest pain at rest
23. ❑ Chest pain with activity
24. ❑ Irregular heartbeat

Gastrointestinal

25. ❑ Abdominal pain
26. ❑ Diarrhea
27. ❑ Constipation
28. ❑ Bowel incontinence
29. ❑ Blood in stool
30. ❑ Heartburn
31. ❑ Pain with bowel movement

Urological

32. ❑ Pain/burning with urination
33. ❑ Bloody/cloudy urine
34. ❑ Urinary ncontinence
35. ❑ Increased urinary urgency
36. ❑ Increased urinary frequency

Skin

37. ❑ Rash
38. ❑ Itching
39. ❑ Discoloration

Ear/ Nose/ Throat

40. ❑ Difficulty swallowing
41. ❑ Hoarseness
42. ❑ Voice changes

Extremities

43. ❑ Leg pain with walking
44. ❑ Cold hands
45. ❑ Cold feet

Psychological

46. ❑ Frequent crying
47. ❑ Insomnia
48. ❑ Depression
49. ❑ Anxiety
50. ❑ Hearing voices
51. ❑ Hallucinations

Social Summary

Are you on disability? ❑ Yes ❑ No If yes, since when?_____

Will there be a lawsuit or litigation regarding your injury? ❑ Yes ❑ No

Is this injury work related? ❑ Yes ❑ No

Is there a workers' compensation claim? ❑ Yes ❑ No

If yes, please list the date of injury: _____

Please describe the mechanism of this injury: _____

Currently I am:

1. ❑ Working full-time
2. ❑ Working part-time
3. ❑ Student
4. ❑ Unemployed
5. ❑ Homemaker
6. ❑ Retired

What kind of work do you do?

_____

If not currently working, when did you last work?

_____

What sports/athletic activities do you participate in? _____

_____

Currently I am:

1. ❑ Married
2. ❑ Partnered
3. ❑ Divorced
4. ❑ Single
5. ❑ Widowed

How many children do you have?

_____

What is your height? _____

What is your weight? _____

How much weight have you lost _____ or gained _____ in the last six months?

Medical History

What medical problems have you had?

❑ (1) High blood pressure ❑ (2) Heart Disease ❑ (3) Lung disease ❑ (4) Diabetes

❑ (5) Cancer ❑ (6) Blood problems ❑ (7) Stomach/intestinal problems ❑ (8) Depression

❑ (9) Anxiety ❑ (10) Kidney disease

❑ Other: _____

_____

What surgeries have you had? ❑ None

_____

_____

_____

_____

_____

I have a family history of:

❑ (1) Neck problems ❑ (2) Back problems ❑ (3) Arthritis ❑ (4) Blood clots

❑ (5) Heart disease ❑ (6) Diabetes ❑ (7) Cancer

❑ Other: _____

_____

Do you smoke? ❑ Yes ❑ No ❑ I quit _____ days / months / years ago

How many packs per day? _____

Do you drink alcohol? ❑ Yes ❑ No

How many drinks per day? _____

Do you have any medication allergies? ❑ Yes ❑ No

Please list them: _____

_____

Please list all medications on the next page.

Please list all your medications (including dose and frequency):