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Trinity Spine Center
Spine Questionnaire

Please Complete ALL 4 Pages of the form in blue/black ink

Name _____ SS#_____ Date_____
Last First M.I

Home #_____ Work #_____ Cell/Other#_____
Emergency contact name _____ Phone#_____
Referring doctor _____ Address_____
Primary care doctor_____ Address_____
Employer_____ Address_____
Your Age_____ Male Female Are You Right Handed Left Handed
Is this a second opinion for treatment? Yes No
What is the main problem (s) for which you are seeking treatment at the Spine Center

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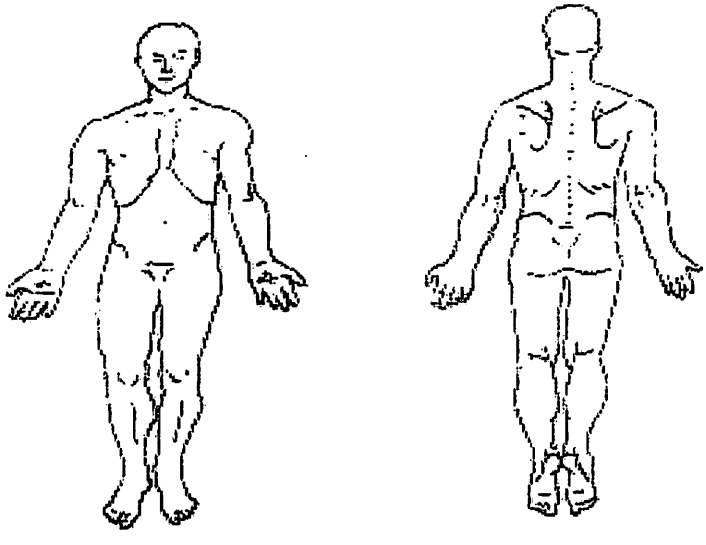
Height: _____ Ft._____inch. Weight_____lbs

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins & Needles	Burning	Stabbing (Sharp) Pain	Aching
=====	ooooo	XXXXX	/////	*****



Please circle on the line below how bad your pain is NOW.

Back Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Worst**
Leg Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Worst**
Neck Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Worst**
Arm Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Worst**

Patient Signature:_____Date_____

I attest that all the information is accurate.

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Doctor #_____

Trinity Spine Center
Spine Questionnare (Continued)

1. When did your present problem start? _____

2. Have you had similar pain in the past? ☐ No ☐ Yes, **If Yes, when** _____

3. How did your pain start? *(Check all below that apply to you)*

☐ Suddenly ☐ Lifting ☐ Bending ☐ Twisting ☐ Pulling
☐ Gradually ☐ After a fall ☐ No apparent cause ☐ Accident on _____

4. What activities make your pain worse? *(Check all below that apply to you)*

☐ Lying ☐ Sitting ☐ Exercise (During) ☐ Bending Forward ☐ Twisting
☐ Standing ☐ Walking ☐ Exercise (After) ☐ Bending Backward ☐ Coughing

5. What reduces your pain *(Check all below that apply to you)*

☐ Lying ☐ Sitting ☐ Exercise (During) ☐ Bending Forward ☐ Twisting
☐ Standing ☐ Walking ☐ Exercise (After) ☐ Bending Backward ☐ Coughing

6. What medications (including dosages) are you taking for your pain? ☐ NONE

_____

_____

Please include all prescription & non-prescription (over the counter) medicine, continue on reverse side

7. What conservative treatments have you tried for this current pain? *(Check all below that apply)*

☐ Physical Therapy, Who? _____ ☐ Home exercises ☐ Acupuncture ☐ Decompression
☐ Chiropractic, Who? _____ ☐ Protective Bracing ☐ Pain Management, Who?_____
☐ Laser Spine Surgery (LSI in Tampa or Dr. Bonati), When?_____

8. Have you been seen for this current pain by: ☐ I have not been evaluated or treated

☐ Primary M.D./ PA/ NP_____ ☐ Emergency Room (Date)_____
☐ Urgent Care (Date) _____ ☐ Hospitalized (Date)_____

9. Have you had any of the following tests? ☐ No test performed

☐ X-rays (Date)_____ ☐ MRI (Date)_____ ☐ CT Scan (Date)_____
☐ EMG/NCS (Date)_____ ☐Other _____

10. Have you had surgery for this pain or similar pain? ☐ No ☐ Yes

If Yes, Please list below the type of surgery you had, when and where performed, and the name of the surgeon:

_____

_____

11. Is your pain due to a work related injury? ☐ No ☐ Yes **If Yes, when?** _____
12. Are you still working? ☐ No ☐ Yes **If No, last Date on job:** _____
13. Is your pain due to an auto accident? ☐ No ☐ Yes **If Yes, when?** _____
14. Is a lawyer involved in your injury? ☐ No ☐ Yes _____
If Yes, please provide us with your lawyer's name, address, & telephone number _____

_____

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Trinity Spine Center
Spine Questionnare (Continued)

15. Review of Symptoms: ***(Please check all items below that apply to you)***

☐ UNEXPLAINED Weight loss/gain	☐ Changes in appetite	☐ Mood Changes
☐ Bladder Accidents/Incontinence	☐ Arm Numbness	☐ Fatigue
☐ Bowel Accidents/Incontinence	☐ Leg Numbness	☐ Stiffness
☐ Night Sweats	☐ New Swelling (Legs or Arms)	☐ Joint Pain
☐ Fever	☐ Change in Handwriting	☐ Poor Sleep
☐ Genital Numbness	☐ Difficulty walking	☐ Rashes
☐ Severe Nighttime pain	☐ New Balance Problems	☐ Bruising/Bleeding
☐ Recent Infections	☐ Difficulty buttoning buttons	☐ Visual Difficulties

☐ Other _____

16. Past Medical History: ***(Please check all items below that apply to you)*** ☐None

☐ Heart Disease ☐ High Blood Pressure ☐ Diabetes ☐ Kidney Disease
☐ Osteoarthritis ☐ Liver Disease ☐ Ulcers ☐ Lung Disease ☐ Thyroid Disease
☐ Seizures/Epilepsy ☐ Psychiatric Illness ☐ Osteoporosis ☐ Acid Reflux ☐ High Cholesterol
☐ Cancer (please specify) _____ ☐ Fibromyalgia ☐ Rheumatoid Arthritis
☐ Other (please specify) _____

17. Past Surgical History: ***(Please check all items below that apply to you)*** ☐None

☐ Lumbar (Lower Back) ☐ Heart ☐ Stents ☐ Lung ☐ Kidney ☐ Thyroid ☐Breast
☐ Cervical (Neck) ☐ Bowel ☐ Hernia ☐ Gallbladder ☐Prostate ☐Arm/Leg, What?_____
☐ Other (Please Describe) _____

18. Allergies: Please check ALL medications that apply to you and the reaction/s you have:

☐Penicillin (Reaction) _____ ☐Sulfa (Reaction)_____ ☐ Codeine (Reaction)_____
☐Iodine (Reaction) _____ ☐ Other_____

19. Medications: Please list ALL medications that you are taking as well as dosages and how often.

_____ _____ _____ _____
_____ _____ _____ _____

Are you taking any blood thinners? ☐No ☐Yes If Yes, check all that apply and list dosages:
☐ Aspirin_____ ☐ Plavix_____ ☐ Coumadin_____ ☐ Other_____

20. Family History: ***(Please check any diseases diagnosed in your blood relatives)*** ☐None

☐Cancer ☐Bleeding disorders ☐Stroke ☐Diabetes ☐Cardiac ☐Arthritis ☐Back/Neck Pain Other_____

21. Social History: ***(Please check all questions)***

Are you: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Do you live: ☐Alone ☐With others: _____ ☐Retirement Home? _____
Occupation: ☐Retired ☐Social Security Disability ☐Employed Current Occupation_____
Is your job: ☐Sedentary ☐Light ☐Medium ☐Heavy
Have you ever smoked? ☐No ☐Yes ☐Quit Packs per day, Number of years? _____
Do you currently drink alcohol? ☐ No ☐Yes What? _____ How much per week? _____
Do you currently use illicit drugs? ☐No ☐Yes What? _____ How often? _____
Highest level of education? ☐High School ☐College ☐Graduate ☐Other _____

Patient Signature:_____Date_____

I attest that all the information is accurate.

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Trinity Spine Center
Spine Questionnaire (Contiued)

Please Read: This questionnaire has been designed to give the doctor information on how your pain has affected your ability to manage everyday life. *PLEASE ANSWER EVERY SECTION AND MARK IN EACH SECTION ONLY ONE ANSWER* that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes you

Section #1:PAIN INTENSITY
- ☐ I can tolerate the pain I have without pain killers
- ☐ The pain is bad but I manage without pain killers
- ☐ Pain killers give me complete relief of pain
- ☐ Pain killers give me moderate relief of pain
- ☐ Pain killers give me very little relief of pain
- ☐ Pain killers have no effect on pain and I do not use them.

Section #2: PERSONAL CARE (Washing, Dressing, Ect.)
- ☐ I can look after myself normally without extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself but I am slow & careful
- ☐ I need some help but manage most of my personal care
- ☐ I need some help everyday in most aspects of self care sleep
- ☐ I do not get dressed, wash with difficult & stay in bed

Section #3:LIFTING
- ☐ I can lift heavy weights without causing pain
- ☐ I can lift heavy weights but it give extra pain
- ☐ Pain prevents me from lifting heavy weights off of the floor but I manage if they are conveniently positioned
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are convenient.
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Section #4: WALKING
- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 Mile
- ☐ Pain prevents me from walking more than ½ Mile
- ☐ Pain prevents me from walking more than ¼ Mile
- ☐ I can only walk using a stick/cane or crutches
- ☐ I am in bed most of the time and have to crawl to the Toilet

Section #5: SITTING
- ☐ I can still sit in a chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than an hour
- ☐ Pain prevents me from sitting more than a ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section # 6:STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want But it give me extra pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than a ½ hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Section # 7:SLEEPING
- ☐ 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
- ☐ Even when I take tablets, I have less than 2 hours
- ☐ Pain prevents me from sleeping at all.

Section #8:EMPLOYMENT / HOMEMAKING
- ☐ Job/homemaking causes no extra pain
- ☐ Job/homemaking increases pain, but I can still perform
- ☐ Can perform most duties, pain prevents heavier activity
- ☐ Pain prevents me from doing anything but light duties
- ☐ Pain prevents me from doing even light duties
- ☐ Pain prevents me from doing ANY job/homemaking

Section #9 SOCIAL LIFE
- ☐ My social life is normal and causes no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my life apart from limiting my more energetic interests (dancing , ect)
- ☐ Pain restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to home
- ☐ I have no social life because of pain

Section # 10: TRAVELING
- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but give extra pain
- ☐ Pain is bad but I can manage to journey over 2 hours
- ☐ Pain restricts me to journeys over 1 hour
- ☐ Pain restricts me to short necessary journeys less than 30 min.
- ☐ Pain prevents me from traveling except to the doctor or hospital

TOTAL(Office use):_____

Patient Signature:_____Date_____

I attest that all the information is accurate.