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octor #________

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

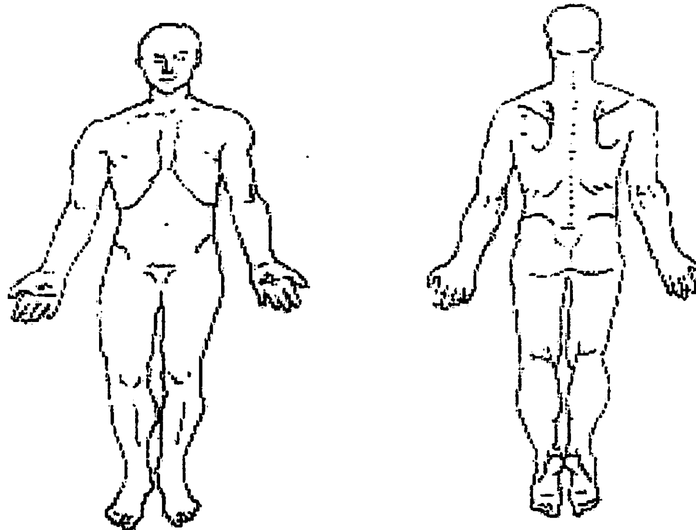
What is the main problem (s) for which you are seeking treatment at the Spine Center

____

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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Patient Account# _____
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 ____________

____

Patient Signature:__________________Date______________

I attest that all the information is accurate.

Office Use Only
Patient Account# _____
Doctor #___________

Trinity Spine Center
Spine Questionnare (Continued)

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

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

Spine and Orthopaedic Specialists, PLLC
Trinity Spine Center
2040 Short Avenue, Suite 100
Odessa, Fl, 33556

The Neck Disability Index

Patient name: ______________________________ File#__________ Date:__________

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing, Dressing, etc.)

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes 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; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- ☐ 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, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in my neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.