Please complete this section regarding your current condition. Your careful answers will help us to understand your problem and design the best treatment program for you.

CHARACTERISTICS OF PAIN:

How long have you had your current problem?
  _____ weeks  _____ months  _____ years

Below, CIRCLE THE #1 PROBLEM for which you are seeking treatment.

- Low back or buttock pain
- Right leg pain Left leg pain
- Pain in both legs
- Right leg numbness Left leg numbness
- Numbness in both legs
- Difficulty walking
- Neck pain Right arm pain
- Left arm pain
- Pain in both arms Right arm numbness Left arm numbness
- Numbness in both arms
- Other:

Above, UNDERLINE THE #2 PROBLEM for which you are seeking treatment.

Other problems (please describe): ________________________________

WHERE IS YOUR PAIN NOW?

On the diagram below, place an X in the area(s) you feel the most pain. Place an O on the body diagram where you feel numbness or tingling.

Right  Back  Front  Left

PAIN IS BEST DESCRIBED AS:

- Dull ache
- Sharp
- Burning
- Electric shock
ONSET OF PAIN: How did your current symptoms start?
- Injury at work ________ date of injury, at work
- Injury, not at work ________ date of injury, not at work
- Motor vehicle accident ________ date of accident
- Undetermined
- Other: __________________________________________

SEVERITY OF PAIN: In general, what is the intensity of your pain (circle one)?

No Pain 01 2 3 4 5 6 7 8 9 10  Worse Possible Pain

In general, how is this problem affecting your life (please check one)?
- Nuisance
- Major problem
- Minor problem
- Catastrophe

TIMING OF PAIN: How often do you have your pain (please check one)?
- Occasionally (less than 30% of the time)
- Nearly constantly (60 to 95% of the time)
- Intermittently (30-60% of the time)
- Constantly (100% of the time)

RELIEVING AND AGGRAVATING FACTORS:
How do the following affect your pain (please check one for each item):
- Lying down
- Standing
- Sitting
- Walking
- Exercise
- Coughing/Sneezing
- Bowel Movements

Have you had any recent change in bowel or bladder habits?
- No 1
- Yes Please describe: ______________________

ACTIVITIES AND YOUR PAIN:
How many blocks can you walk?
- Less than a block
- 1-2 blocks
- 2-5 blocks
- 5-10 blocks
- Greater than 10 blocks

How often during the day do you lie down because of pain?
- Never
- Seldom
- Sometimes
- Often
- Constantly

To assist walking, I use a:
- Cane
- Walker
- Wheelchair
- No assistance device

I am NOT able to perform the following activities of daily living (check all that apply):
- Doing yard work or shopping
- Performing household chores
- Going to work
- Socializing with friends
- Participating in recreational activities
- Exercising
TREATMENTS FOR YOUR SPINE TO DATE: (Check all that apply).

☐ Physical therapy  ☐ Facet blocks  ☐ Epidural steroid injections
☐ TENS unit  ☐ Back injections, not sure what type  ☐ Spinal surgery (describe below)

<table>
<thead>
<tr>
<th>Date of Spinal Surgery</th>
<th>Title of Spine Operation</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CURRENT MEDICATIONS FOR PAIN: (Check all that apply):

<table>
<thead>
<tr>
<th>i</th>
<th>Narcotics</th>
<th>Narcotic Dose and Frequency</th>
<th>NSAIDs/Tylenol</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>Vicodin (Hydrocodone/APAP)</td>
<td></td>
<td>Tylenol</td>
</tr>
<tr>
<td>☐</td>
<td>Darvocet (Propoxyphene/APAP)</td>
<td></td>
<td>Motrin</td>
</tr>
<tr>
<td>☐</td>
<td>Oxycodone (Percocet/Tylox)</td>
<td></td>
<td>Celebrex</td>
</tr>
<tr>
<td>☐</td>
<td>Oxycontin</td>
<td></td>
<td>Bextra</td>
</tr>
<tr>
<td>☐</td>
<td>Morphine</td>
<td></td>
<td>Vioxx</td>
</tr>
<tr>
<td>☐</td>
<td>MSContin</td>
<td></td>
<td>Advil</td>
</tr>
<tr>
<td>☐</td>
<td>Diiaudid</td>
<td></td>
<td>Aleve</td>
</tr>
<tr>
<td>☐</td>
<td>Fentanyl (Duragisc)</td>
<td></td>
<td>Ibuprofen</td>
</tr>
<tr>
<td>☐</td>
<td>Methadone</td>
<td></td>
<td>Naprosyn</td>
</tr>
<tr>
<td>☐</td>
<td>Demerol</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>☐</td>
<td>Other:</td>
<td></td>
<td>(approximate date).</td>
</tr>
</tbody>
</table>

If Yes to above, 1 have been on narcotic pain medications since

<table>
<thead>
<tr>
<th>Muscle Relaxants</th>
<th>Other Related Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Soma</td>
<td>☐ Neurontin</td>
</tr>
<tr>
<td>☐ Flexeril</td>
<td>☐ Anti-depressant medication</td>
</tr>
<tr>
<td>☐ Valium</td>
<td>☐ Anti-anxiety medication</td>
</tr>
<tr>
<td>☐ Baclofen</td>
<td>☐ Other:</td>
</tr>
<tr>
<td>☐ Skelaxin</td>
<td></td>
</tr>
</tbody>
</table>

Completed by: ____________________________________________       __________   
Patient/Guardian Date

This questionnaire has been reviewed with the patient

Physician/Resident/PA or Nurse's Signature Date

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