



VISIT QUESTIONNAIRE

1. When did your pain first occur? _____ 2. Was this due to an injury? No Yes If yes, date of injury _____
3. If this is an injury, are you represented by an attorney? No Yes Name _____
4. Who referred you to The SpineCare Center? _____
5. Who is your primary care physician? _____

6. Location(s) of your pain: _____

7. Have you had any of the following in your legs and/or feet:

	YES	NO	If you answered yes, where was it located?							
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Both Legs	<input type="checkbox"/> Both Feet		
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Both Legs	<input type="checkbox"/> Both Feet		
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Both Legs	<input type="checkbox"/> Both Feet		
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Both Legs	<input type="checkbox"/> Both Feet		

8. Have you had any of the following in your shoulders, arms and/or hands:

	YES	NO	If you answered yes, where was it located?								
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Hand	<input type="checkbox"/> Both Shoulders	<input type="checkbox"/> Both Arms	<input type="checkbox"/> Both Hands
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Hand	<input type="checkbox"/> Both Shoulders	<input type="checkbox"/> Both Arms	<input type="checkbox"/> Both Hands
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Hand	<input type="checkbox"/> Both Shoulders	<input type="checkbox"/> Both Arms	<input type="checkbox"/> Both Hands
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Left Hand	<input type="checkbox"/> Both Shoulders	<input type="checkbox"/> Both Arms	<input type="checkbox"/> Both Hands

9. Have you had any of the following:

	YES	NO	YES	NO
Loss of bowel control	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>
Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>		

10. Did this pain start after a known injury or fall? Yes No

11. Mark any of the following that describe your pain or symptoms:

- mild occasional crushing occurring at rest stabbing intermittent muscle spasms _____
- moderate aching dull pressure stinging cramping
- severe activity related fullness sharp throbbing occurring at night
- constant burning heaviness shooting tightening squeezing

*Please document location of muscle spasms _____

12. Please mark any of the following tests or studies you have had done for the problem that you are here for today:

- no work up CT myelogram Lab work
- plain films MRI MRA
- CT scan EMG-NCV Bone Scan
- Where were they performed? _____

13. Have you tried any of the following treatments for the problem that you are here for today:

	Yes	Did it help?		Yes	Did it help?
nothing tried	<input type="checkbox"/>	YES <input type="checkbox"/>	Over the Counter pain meds	<input type="checkbox"/>	YES <input type="checkbox"/>
rest	<input type="checkbox"/>	YES <input type="checkbox"/>	NSAIDs (such as Ibuprofen, Aleve, Advil, Etc.)	<input type="checkbox"/>	YES <input type="checkbox"/>
ice	<input type="checkbox"/>	YES <input type="checkbox"/>	narcotic pain meds	<input type="checkbox"/>	YES <input type="checkbox"/>
heat	<input type="checkbox"/>	YES <input type="checkbox"/>	chiropractic therapy	<input type="checkbox"/>	YES <input type="checkbox"/>
acupuncture	<input type="checkbox"/>	YES <input type="checkbox"/>	physical therapy	<input type="checkbox"/>	YES <input type="checkbox"/>
Muscle relaxants	<input type="checkbox"/>	YES <input type="checkbox"/>	When? _____		

14. Have you had anything to eat or drink in the past 6 hours? No Yes If yes, what and when? _____

15. Have you been sick or had fever since your last visit? No Yes

16. Did you get any relief for any length of time after your last injection or nerve block? YES NO If yes, what percent better? _____

17. Do you take a blood thinner? No Yes Name of Blood Thinner _____

18. Who is driving you home? _____ You must leave a contact phone #: _____

Will this person be available within 10 minutes from The SpineCare Center or waiting in the waiting room?

19. Rate your pain by circling the number or words that best describes your pain:

At its **WORST** in the last month or since here last
 No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
 At its **LEAST** in the last month or since here last
 No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
TODAY?
 No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

20. Circle the number or words that best describe how much pain interferes with your life.

No interference 1 2 3 4 5 6 7 8 9 10 Unable to do usual activities

21. Check when your pain is worse: Morning Afternoon Evening Night or No typical pattern

22. Sleep: Average number of hours per night: _____ Sleep quality Good Fair Poor

Do you **currently** have any of the following symptoms or problems with:

YES

NO

If Yes, please explain below:

YES

NO

General:

fever	<input type="checkbox"/>	<input type="checkbox"/>	
chills	<input type="checkbox"/>	<input type="checkbox"/>	
fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
weight loss	<input type="checkbox"/>	<input type="checkbox"/>	

HEENT:

vision problems	<input type="checkbox"/>	<input type="checkbox"/>	
hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	
speech problems	<input type="checkbox"/>	<input type="checkbox"/>	

Skin:

open wounds	<input type="checkbox"/>	<input type="checkbox"/>	
rash	<input type="checkbox"/>	<input type="checkbox"/>	
lesions	<input type="checkbox"/>	<input type="checkbox"/>	

Cardiac:

chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
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Pulmonary:

cough	<input type="checkbox"/>	<input type="checkbox"/>	
wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	

GI:

nausea	<input type="checkbox"/>	<input type="checkbox"/>	
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
loss of bowel control	<input type="checkbox"/>	<input type="checkbox"/>	

GU:

difficulty urinating dysuria	<input type="checkbox"/>	<input type="checkbox"/>	
blood in urine (hematuria)	<input type="checkbox"/>	<input type="checkbox"/>	
urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>	
urinary urgency	<input type="checkbox"/>	<input type="checkbox"/>	
loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	

Musculoskeletal:

back pain	<input type="checkbox"/>	<input type="checkbox"/>	
joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
leg pain	<input type="checkbox"/>	<input type="checkbox"/>	
arthritis	<input type="checkbox"/>	<input type="checkbox"/>	

Endo:

diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	

Psych:

nervousness	<input type="checkbox"/>	<input type="checkbox"/>	
anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
mood swings	<input type="checkbox"/>	<input type="checkbox"/>	
depression	<input type="checkbox"/>	<input type="checkbox"/>	

Heme:

anemia	<input type="checkbox"/>	<input type="checkbox"/>	
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Immunological:

HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	

Neuro:

seizures	<input type="checkbox"/>	<input type="checkbox"/>	
tremors	<input type="checkbox"/>	<input type="checkbox"/>	
syncope	<input type="checkbox"/>	<input type="checkbox"/>	
memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	
loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	
headache	<input type="checkbox"/>	<input type="checkbox"/>	
blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Signature

Date/Time

Nurse Signature

Date/Time

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