

# The Spine and Sports Center







## RETURN PATIENT QUESTIONNAIRE

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

### QUESTIONS ABOUT MY CURRENT PROBLEM

1. When were you last seen?
2. What are you being seen for?
3. Describe your current pain
4. Generally speaking, are your symptoms getting better, worse or the same? \_\_\_\_\_
5. Circle the number between 0 and 10 to indicate your level of pain in this last week:

											
	No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst					
When it felt the worst this week	0	1	2	3	4	5	6	7	8	9	10
When it felt the best this week	0	1	2	3	4	5	6	7	8	9	10
Average for the week	0	1	2	3	4	5	6	7	8	9	10

6. How many of the 4 function limitations are you now able to do? \_\_\_\_\_

### TREATMENT HISTORY

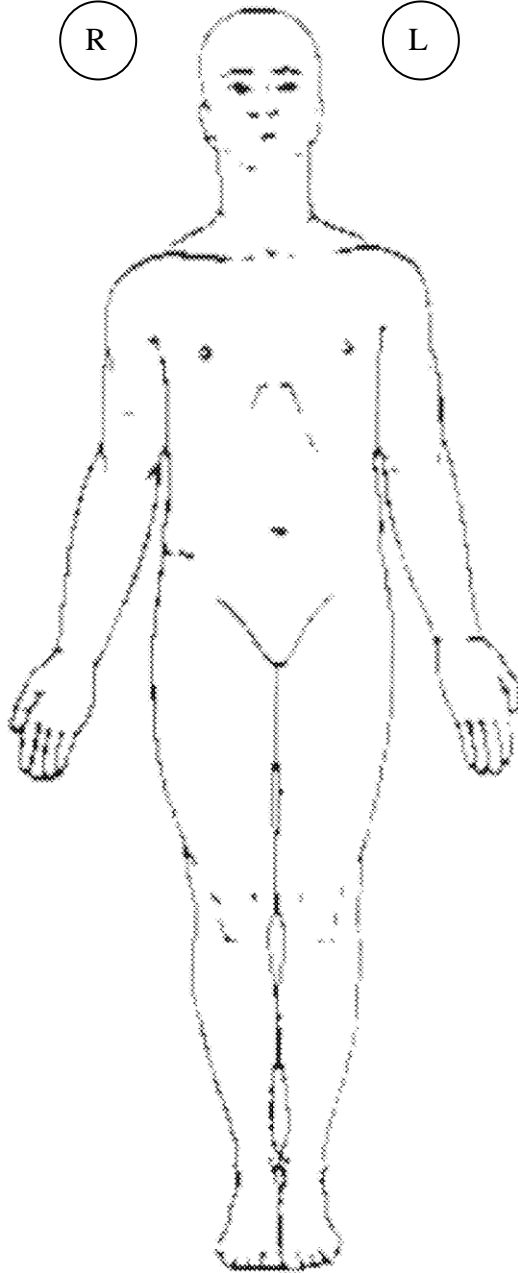
Write all treatments you have received for this problem since your last visit:

- Medication Changes
- Physical Therapy and/or Occupational Therapy. Where and Dates?  
What did they teach you to do?
- Injections or Nerve Blocks.  
Where and dates? \_\_\_\_\_  
What injections were done? \_\_\_\_\_  
Surgery? If yes, what? \_\_\_\_\_
- OTHER THINGS TRIED:

Mark the areas on the body where you feel your normal  
pain/numbness/tingling

R

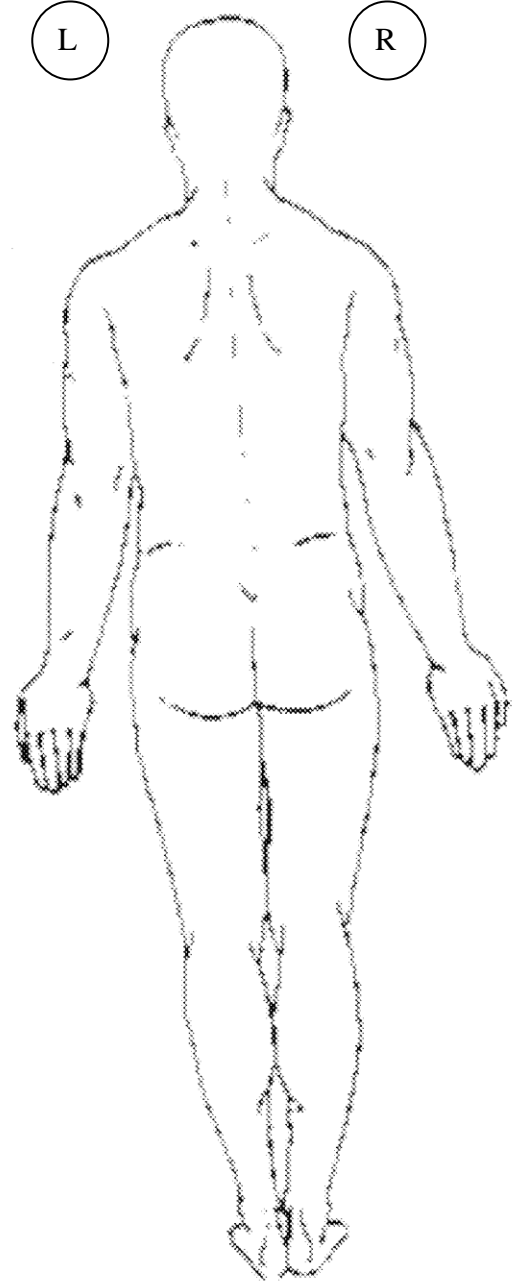
L



FRONT

L

R



BACK

**FUNCTIONAL STATUS:**

yes  no Do you have trouble getting to sleep because of pain

yes  no Do you exercise? If yes how often \_\_\_\_\_

**MEDICATIONS I AM CURRENTLY TAKING FOR ANY REASON  
(including non-prescription drugs)**

Drug Name	Dose	How Often	For Pain Meds Only - - Does it help?
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know
			<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know

**LIST ALL KNOWN ALLERGIES**

**MEDICAL HEALTH HISTORY**

**PLEASE LIST ANY CHANGES IN MEDICAL HEALTH HISTORY OR ANY RECENT HOSPITALIZATIONS OR VISITS TO DOCTORS**

## THINGS THAT I AM ***CURRENTLY EXPERIENCING***

CHECK ALL THAT APPLY:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Fever or chills    | <input type="checkbox"/> Bowel incontinence  | <input type="checkbox"/> Urinary incontinence  | <input type="checkbox"/> Frequent Constipation |
| <input type="checkbox"/> Hot or cold spells | <input type="checkbox"/> Change of Vision    | <input type="checkbox"/> Swollen ankles        | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Recent wt. change  | <input type="checkbox"/> Loss of hearing     | <input type="checkbox"/> Calf cramps w/walking | <input type="checkbox"/> Frequent urination    |
| <input type="checkbox"/> Nervous exhaustion | <input type="checkbox"/> Ear pain            | <input type="checkbox"/> Poor appetite         | <input type="checkbox"/> Burning on urination  |
| <input type="checkbox"/> Hoarseness         | <input type="checkbox"/> Tooth ache          | <input type="checkbox"/> Difficulty urinating  | <input type="checkbox"/> Nosebleeds            |
| <input type="checkbox"/> Gum trouble        | <input type="checkbox"/> Get up during night | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea or vomiting    |
| <input type="checkbox"/> Morning cough      | <input type="checkbox"/> Stomach pain        | <input type="checkbox"/> Frequent headaches    | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Ulcers             | <input type="checkbox"/> Blackouts           | <input type="checkbox"/> Reading glasses       | <input type="checkbox"/> Frequent belching     |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Frequent diarrhea     | <input type="checkbox"/> Frequent rash         |

***Women ONLY***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Frequent Spotting |
|--|--|--|

**ANYTHING ELSE YOU WISH TO SHARE WITH THE DOCTOR**