

**FLORIDA ORTHOPAEDIC INSTITUTE SPINE
FIRST VISIT QUESTIONNAIRE**

Please circle answers to questions that pertain to your problem. You may select more than one answer per question. This information will help get an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit note. If you have any questions, please ask for assistance.

Referred by: _____ Is this a second opinion? _____

NAME _____ MR# _____ DATE _____ DR _____

AGE: _____ ARE YOU: (A) Right handed (B) Left handed (C) Ambidextrous

SEX: (A) Male (B) Female OCCUPATION: _____

COMPLAINT (What are you being seen for?)

- A. Neck pain
- B. Neck Pain with headaches
- C. Upper Back Pain
- D. Lower Back Pain
- E. Right Leg Pain
- F. Left Leg Pain
- G. Right Arm Pain
- H. Left Arm Pain
- I. Scoliosis
- J. Other _____

Do you have any:

- A. Weakness
- B. Numbness
- C. Tingling
- D. If so, where?
Describe _____

If one or more of the above is chosen, which is the most problematic? _____

Which term best describes your neck/back pain?

- A. Sharp
- B. Stabbing
- C. Burning
- D. Like electricity
- E. Dull ache
- F. Pins and needles

Which term best describes your arm/leg pain?

- A. Sharp
- B. Stabbing
- C. Burning
- D. Like electricity
- E. Dull ache
- F. Pins and needles

When did the problem start? _____

If problem was caused from an injury, what is the date of injury? _____

Was the injury job related? (A) Yes (B) No

How did the injury occur? (20)

- A. No injury
- B. Motor vehicle accident - no litigation
- C. Motor vehicle accident - litigation pending
- D. Motor vehicle accident - litigation complete
- E. Fall
- F. Sports or recreation
- G. Job related
- H. Other _____

If motor vehicle accident, were you:

- A. Driver
- B. Front seat passenger
- C. Rear seat passenger
- D. Motorcycle driver
- E. Motorcycle passenger
- F. Other _____

Were you wearing a seat belt? (A) Yes (B) No

Other injuries due to this condition: (A) None (B) Yes, explain _____

Please briefly explain the circumstances that led to your condition:

What treatments have you already received for this condition?

- A. Medications (list) _____
- B. Physical therapy (how many weeks ?) _____
- C. Chiropractic care (how many weeks ?) _____
- D. Epidural injections: How many injections? _____ When was the last ? _____
- E. Other (please list) _____

Since the pain/condition began it: (21)

- A. Has improved
- B. Has worsened
- C. Has stayed the same
- D. Comes and goes (fluctuates)

What time of the day is pain most intense? (32)

- A. On first arising in the morning
- B. During the daytime or while at work
- C. At the end of the day before bedtime
- D. During the night

What aggravates the pain? (22)

- A. Walking
- B. Standing
- C. Sitting
- D. Lying down
- E. Activity in general
- F. Stooping/bending
- G. Nothing in particular
- H. Other/comments _____

What makes the pain better?

- A. Sitting
- B. Lying down
- C. Walking
- D. Standing
- E. Nothing in particular
- F. Other/comments _____

Does the pain awaken you from sleep?

- A. Never
- B. Occasionally
- C. Frequently

Does the pain keep you from sleeping?

- A. Never
- B. Occasionally
- C. Frequently

Do you have any difficulty walking? (23)
 A. No
 B. Yes, can walk unlimited distances
 C. Yes, can walk less than a mile
 D. Yes, can walk only 1-2 blocks
 E. Yes, can walk less than 1 block
 F. Yes, non-ambulatory (cannot walk)
 G. Other _____

Is walking difficulty related to this condition?
 A. Yes
 B. No, explain _____

Have you had any problems with bowel, bladder, or sexual functions since this condition began? (24)
 A. No
 B. Yes: Please explain _____

Have you had a previous back or neck problem? (25)
 A. No
 B. Yes: Explain _____

Do you exercise regularly? (26)
 A. No
 B. Yes: How often? _____

PAST MEDICAL/SURGICAL HISTORY

Do you have a history of any of these medical conditions?

| | | | | | |
|----------------------------------|-----|----|--------------------------------|-----|----|
| Diabetes | YES | NO | Liver disease | YES | NO |
| ____Diet controlled | | | Kidney disease | YES | NO |
| ____Medication controlled | | | Hepatitis | YES | NO |
| ____Insulin controlled | | | Type? _____ | | |
| High blood pressure | YES | NO | Immune disorder | YES | NO |
| Heart disease | YES | NO | Seizures | YES | NO |
| ____Chest pain/angina | | | Eye problems | YES | NO |
| ____Heart attack, Date _____ | | | Headaches | YES | NO |
| ____Valve disease | | | Thyroid disorder | YES | NO |
| Cancer/Tumor | YES | NO | Osteoarthritis (wear and tear) | YES | NO |
| What type? _____ | | | Rheumatoid arthritis | YES | NO |
| Ulcers | YES | NO | Asthma | YES | NO |
| Lung disease including emphysema | YES | NO | Mental disorder | YES | NO |
| Stroke | YES | NO | Explain _____ | | |
| When? _____ | | | Other _____ | | |
| Circulation problems | YES | NO | | | |
| High cholesterol | YES | NO | | | |

ALLERGIES

Do you have any Allergies? (28)

- A. No known allergies including iodine/contrast dye or shellfish
 B. Yes, please list _____

SOCIAL AND FAMILY HISTORY

Marital status: (A) Single (B) Married (C) Divorced (D) Widowed

How many children do you have? _____

What is the highest level of education you have completed?

- (A) Some high school (B) High school (C) Trade school (D) College (E) Professional school

Do you smoke? (A) No (B) Yes; packs per day? _____

How many years have you been smoking? _____

Do you smoke a pipe? (A) No (B) Yes How often? _____

Do you smoke cigars? (A) No (B) Yes How often? _____

Do you use smokeless tobacco? (A) No (B) Yes How much? _____

Did you ever smoke regularly before? (A) No (B) Yes; packs per day? _____

How many years did you smoke? _____ When did you quit smoking? _____

How much alcohol do you consume in an average week (beer, wine, etc.)? (29)

- A. None
 B. Less than 6 drinks
 C. 6-12 drinks
 D. 12-24 drinks
 E. 24-48 drinks
 F. More than 48 drinks

What is your current work status? (30)

- A. Regular employment - no restrictions
 B. Full time with restrictions
 C. Part time by choice
 D. Part time with restrictions
 E. Part time due to a spine problem
 F. Part time due to other medical reason, Specify _____
 G. Retired by choice
 H. Retired due to a spine problem
 I. Retired due to other medical reason, Specify _____
 J. Unemployed - looking for work with no restrictions
 K. Unemployed - looking for light duty work
 L. Unemployed
 M. Currently not working due to a spine problem
 N. Currently not working due to other medical reason, Specify _____
 O. Student

Do you have a family history of any of these diseases? (Circle all that are appropriate) (31)

- A. None
- B. Back or neck problems
- C. Cancer
- D. Diabetes
- E. Heart disease
- F. Hypertension
- G. Osteoarthritis (wear & tear)
- H. Rheumatoid arthritis
- I. Scoliosis
- J. Stroke
- K. Other _____

REVIEW OF SYSTEMS

Have you recently experienced any of the following?

General:

| | | |
|--------------|-----|----|
| Weight gain | YES | NO |
| Weight loss | YES | NO |
| Fever | YES | NO |
| Chills | YES | NO |
| Night sweats | YES | NO |

Skin:

| | | |
|-----------------|-----|----|
| Change in moles | YES | NO |
| Breast lumps | YES | NO |

Eyes:

| | | |
|----------------|-----|----|
| Loss of vision | YES | NO |
| Double vision | YES | NO |

ENT:

| | | |
|--------------|-----|----|
| Hearing loss | YES | NO |
| Nose bleeds | YES | NO |

GI:

| | | |
|------------------------|-----|----|
| Nausea | YES | NO |
| Vomiting | YES | NO |
| Change in bowel habits | YES | NO |
| Heartburn | YES | NO |

Respiratory:

| | | |
|---------------------|-----|----|
| Shortness of breath | YES | NO |
| Coughing/wheezing | YES | NO |

Heart:

| | | |
|--------------|-----|----|
| Chest pain | YES | NO |
| Palpitations | YES | NO |
| Fainting | YES | NO |

GU:

| | | |
|---------------------------|-----|----|
| Frequent urination | YES | NO |
| Difficulty with urination | YES | NO |
| Blood in urine | YES | NO |

Vascular:

| | | |
|----------------------------|-----|----|
| Swelling lower extremities | YES | NO |
| Emboli (blood clots) | YES | NO |

Musculoskeletal:

| | | |
|-----------------|-----|----|
| Muscle weakness | YES | NO |
| Stiffness | YES | NO |
| Joint pain | YES | NO |

Psych:

| | | |
|-------------|-----|----|
| Anxiety | YES | NO |
| Depression | YES | NO |
| Confusion | YES | NO |
| Memory loss | YES | NO |

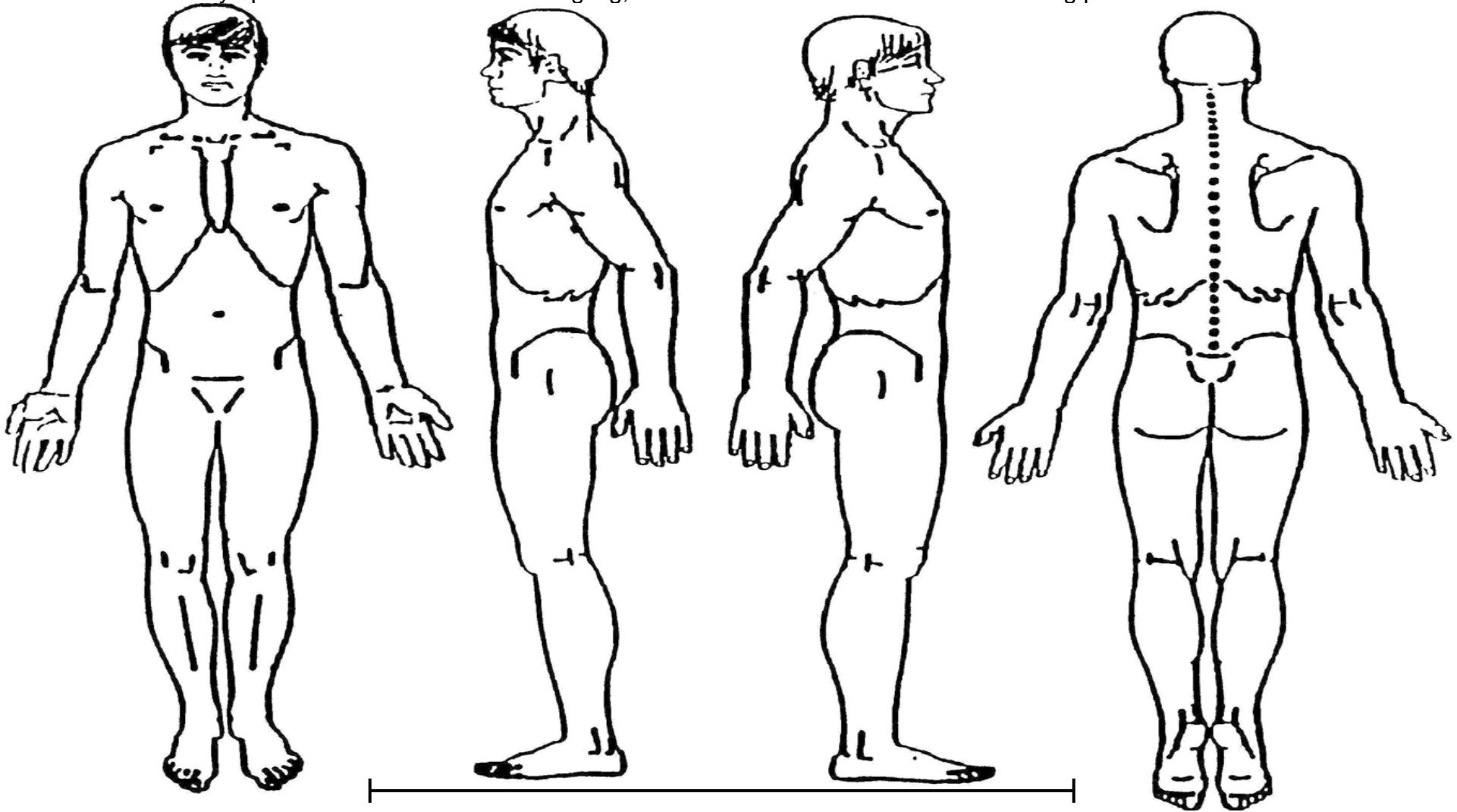
Dr. signature _____

FLORIDA ORTHOPAEDIC INSITUTE SPINE CENTER
PAIN ASSESSMENT Form

Draw the location of your pain on the figures below.

For symptoms of pain, fill in the affected areas with the following pattern: xxxxx

For symptoms of numbness and/or tingling, fill in the affected areas with the following pattern: ooooo



0% (No Pain)

100% (Worst Possible Pain)

PAIN LINE: Draw a perpendicular line across the line above to indicate your typical level of daily pain.