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. 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?
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:

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?

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?

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?

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?

A. No
B. Yes: Please explain _____

Have you had a previous back or neck problem?

A. No
B. Yes: Explain _____

Do you exercise regularly?

A. No
B. Yes: How often? _____

***If you are being seen for NECK PAIN, please complete the following 10 questions:**
(If you are being seen only for Back Pain, please skip to the next section.**)**

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

Personal Care (Washing, Dressing, etc.)
- O I can look after myself normally without causing extra pain.
- O I can look after myself normally, but it causes extra pain.
- O It is painful to look after myself and I am slow and careful.
- O I need some help, but manage most of my personal care.
- O I need help every day in most aspects of self-care.
- O I do not get dressed; I wash with difficulty and stay in bed.

Lifting
- O I can lift heavy weights without extra pain.
- O I can lift heavy weights, but it gives extra pain.
- O Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- O Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- O I can lift very light weights.
- O I cannot lift or carry anything at all.

Reading (Neck)
- O I can read as much as I want to with no pain in my neck.
- O I can read as much as I want to with slight pain in my neck.
- O I can read as much as I want to with moderate pain in my neck.
- O I cannot read as much as I want because of moderate pain in my neck.
- O I cannot read as much as I want because of severe pain in my neck.
- O I cannot read at all.

Headaches
- O I have no headaches at all.
- O I have slight headaches which come infrequently.
- O I have moderate headaches which come infrequently.
- O I have moderate headaches which come frequently.
- O I have severe headaches which come frequently.
- O I have headaches almost all the time.

Concentration
- O I can concentrate fully with no difficulty.
- O I can concentrate fully with slight difficulty.
- O I have a fair degree of difficulty in concentrating.
- O I have a lot of difficulty in concentrating.
- O I have a great deal of difficulty in concentrating.
- O I cannot concentrate at all.

Work
- O I can do as much work as I want to.
- O I can only do my usual work, but no more.
- O I can do most of my usual work, but no more.
- O I cannot do my usual work
- O I can hardly do any work at all.
- O I cannot do any work at all.

Driving
- O I can drive my car without any neck pain.
- O I can drive my car as long as I want with slight pain in my neck.
- O I can drive my car as long as I want with moderate pain in my neck.
- O I cannot drive my car as long as I want because of moderate pain in my neck.
- O I can hardly drive at all because of severe pain in my neck.
- O I cannot drive my car at all.

Sleeping
- O I have no trouble sleeping.
- O My sleep is slightly disturbed (less than 1 hour sleepless).
- O My sleep is mildly disturbed (1-2 hours sleepless).
- O My sleep is moderately disturbed (2-3 hours sleepless).
- O My sleep is greatly disturbed (3-5 hours sleepless).
- O My sleep is completely disturbed (5-7 hours)

Recreation
- O I am able to engage in all of my recreational activities with no neck pain at all.
- O I am able to engage in all of my recreational activities with some pain in my neck.
- O I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- O I am able to engage in a few of my recreational activities because of pain in my neck.
- O I can hardly do any recreational activities because of pain in my neck.
- O I cannot do any recreational activities at all.

*If you are being seen for BACK PAIN, please complete the following questions:

(Low Back) Pain Intensity
- O I have no pain at the moment.
- O The pain is very mild at the moment.
- O The pain is moderate at the moment.
- O The pain is fairly severe at the moment.
- O The pain is very severe at the moment.
- O The pain is the worst imaginable at the moment.

(Low Back) Personal Care (washing, dressing, etc.)
- O I can look after myself normally without causing extra pain.
- O I can look after myself normally, but it causes extra pain.
- O It is painful to look after myself and I am slow and careful.
- O I need some help, but manage most of my personal care.
- O I need help every day in most aspects of self-care.
- O I do not get dressed; I wash with difficulty and stay in bed.

(Low Back) Lifting
- O I can lift heavy weights without extra pain.
- O I can lift heavy weights, but it gives extra pain.
- O Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- O Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- O I can lift very light weights.
- O I cannot lift or carry anything at all.

Walking
- O Pain does not prevent me walking any distance
- O Pain prevents me from walking more than 1 mile
- O Pain prevents me from walking more than ½ mile
- O Pain prevents me from walking more than 100 yards
- O I can only walk using a stick or crutches
- O I am in bed most of the time

Sitting
- O I can sit in any chair as long as I like
- O I can only sit in my favorite chair as long as I like
- O Pain prevents me sitting more than one hour
- O Pain prevents me from sitting more than 30 minutes
- O Pain prevents me from sitting more than 10 minutes
- O Pain prevents me from sitting at all

Standing
- O I can stand as long as I want without extra pain
- O I can stand as long as I want but it gives me extra pain
- O Pain prevents me from standing for more than 1 hour
- O Pain prevents me from standing for more than 30 minutes
- O Pain prevents me from standing for more than 10 minutes
- O Pain prevents me from standing at all

(Low Back) Sleeping
- O I have no trouble sleeping.
- O My sleep is slightly disturbed (less than 1 hour sleepless).
- O My sleep is mildly disturbed (1-2 hours sleepless).
- O My sleep is moderately disturbed (2-3 hours sleepless).
- O My sleep is greatly disturbed (3-5 hours sleepless).
- O My sleep is completely disturbed (5-7 hours)

Sex Life (if applicable)
- O My sex life is normal and causes no extra pain
- O My sex life is normal but causes some extra pain
- O My sex life is nearly normal but is very painful
- O My sex life is severely restricted by pain
- O My sex life is nearly absent because of pain
- O Pain prevents any sex life at all

Social Life
- O My social life is normal and gives me no extra pain
- O My social life is normal but increases the degree of pain
- O Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- O Pain has restricted my social life and I do not go out as often
- O Pain has restricted my social life to my home
- O I have no social life because of pain

Traveling
- O I can travel anywhere without pain
- O I can travel anywhere but it gives me extra pain
- O Pain is bad but I manage journeys over two hours
- O Pain restricts me to journeys of less than one hour
- O Pain restricts me to short necessary journeys under 30 minutes
- O Pain prevents me from travelling except to receive treatment

LUMBAR VISUAL ANALOGUE SCALE

Name _____ **MR#** _____ **Date** _____

INSTRUCTIONS: Please mark a vertical line that best describes your pain at the moment.
EXAMPLE:
No pain _____|_____ As severe as it could be

Low Back Pain:

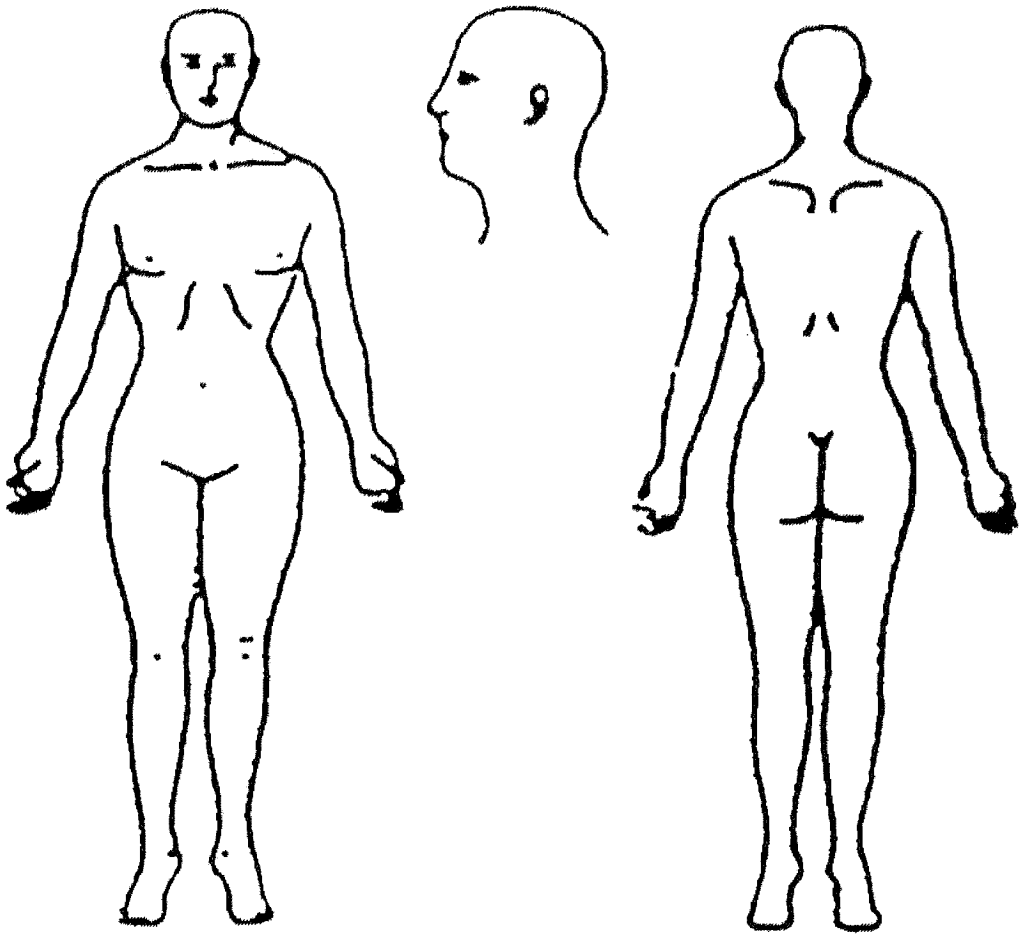
No pain _____ As severe as it could be _____ score

Leg:

No pain _____ As severe as it could be _____ score

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



EQ-5D-5L

Health Questionnaire

Name_____MR#_____Date_____

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

SELF-CARE

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

USUAL ACTIVITIES (*e.g. Work, study, housework, family or leisure activities*)

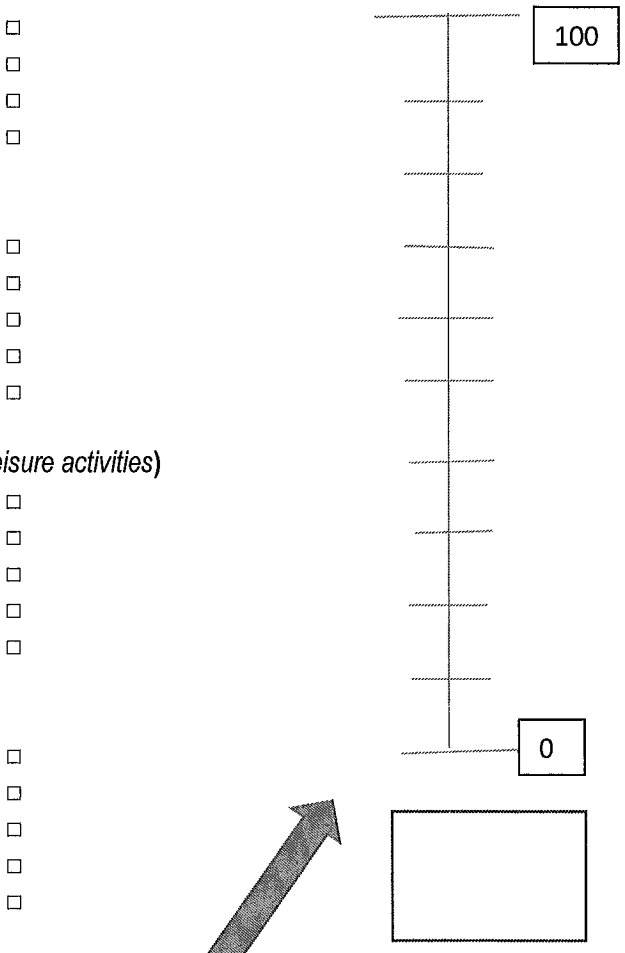
I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

PAIN / DISCOMFORT

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐



We would like to know how good or bad your health is TODAY.
This scale is numbered from 0-100.
100 means the best health you can imagine.
0 means the worst health you can imagine.

Mark an X on the scale to indicate yow your health is TODAY. Please put that score in this box.

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

Name_____ **MR#**_____ **Date**_____

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

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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, 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 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

PAST MEDICAL/SURGICAL HISTORY

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

Diabetes YES NO
_____Diet controlled
_____Medication controlled
_____Insulin controlled
High blood pressure YES NO
Heart disease YES NO
_____Chest pain/angina
_____Heart attack, Date _____
_____Valve disease
Cancer/Tumor YES NO
What type? _____
Ulcers YES NO
Lung disease including emphysema YES NO
Stroke YES NO
When? _____
Circulation problems YES NO

High cholesterol YES NO
Liver disease YES NO
Kidney disease YES NO
Hepatitis YES NO
Type? _____
Immune disorder YES NO
Seizures YES NO
Eye problems YES NO
Headaches YES NO
Thyroid disorder YES NO
Osteoarthritis (wear and tear) YES NO
Rheumatoid arthritis YES NO
Asthma YES NO
Mental disorder YES NO
Explain _____
Other _____

Have you ever had any neck or back (spine) surgery?
A. No
B. Yes: How many? _____

Please list your previous neck and back (spine) operations.

Date	Place	Surgeon	Procedure

Have you had any other surgery besides spine?
A. No
B. Yes: Please list below

Date	Procedure

CURRENT MEDICATIONS

A. None
B. Yes: Please list below

Name	Dose	For what problem?

ALLERGIES

Do you have any Allergies?
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.)?
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?

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)

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:			Heart:		
	Weight gain	YES NO		Chest pain	YES NO
	Weight loss	YES NO		Palpitations	YES NO
	Fever	YES NO		Fainting	YES NO
	Chills	YES NO	GU:		
	Night sweats	YES NO		Frequent urination	YES NO
Skin:				Difficulty with urination	YES NO
	Change in moles	YES NO		Blood in urine	YES NO
	Breast lumps	YES NO	Vascular:		
Eyes:				Swelling lower extremities	YES NO
	Loss of vision	YES NO		Emboli (blood clots)	YES NO
	Double vision	YES NO	Musculoskeletal:		
ENT:				Muscle weakness	YES NO
	Hearing loss	YES NO		Stiffness	YES NO
	Nose bleeds	YES NO		Joint pain	YES NO
GI:			Psych:		
	Nausea	YES NO		Anxiety	YES NO
	Vomiting	YES NO		Depression	YES NO
	Change in bowel habits	YES NO		Confusion	YES NO
	Heartburn	YES NO		Memory loss	YES NO
Respiratory:					
	Shortness of breath	YES NO			
	Coughing/wheezing	YES NO			

Dr. signature _____

Patient Name_____ Date_____ MR#:_____

PREFRERRED PHARMACY INFORMATION

Pharmacy Name	
Pharmacy Street Address	
City, State, Zip	
If address unknown please provide crossroads	
Pharmacy Phone Number	

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:**_____