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 __________________________

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?
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 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

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

Does the pain keep you from sleeping?
A. Never
B. Occasionally
C. Frequently

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?
INSTRUCTIONS: Please mark a vertical line that best describes your pain at the moment.

EXAMPLE:
No pain ______________________ As severe as it could be __________ score

Neck:
No pain ______________________ As severe as it could be __________ score

ARM:
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 /\ /\ /\ /\ Numbness ooooo Pins/Needles **** Burning xxxx Stabbing ////
NECK DISABILITY INDEX

Name ________________________ MR# __________ Date __________

This questionnaire has been designed to give the doctor information as to how your neck 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 have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

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.
☐ I am helpless today 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 - Reading

☐ I can read as much as I want with no pain in my neck.
☐ I can read as much as I want with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I cannot read as much as I want because of moderate pain in my neck.
☐ I can barely read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5 - Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches 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 a significant activities of daily living disability.

\[
\text{Score x 2)} / \text{(Sections x 10)} = \%\text{ADL}
\]

Section 6 - Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7 - Work

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

Section 8 - Driving

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

Section 9 - Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

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

Comments ________________________

%ADL ________________________

Reference: Vened, Mair. JMPT 1991; 14(7): 409-15
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 how your health is TODAY. Please put that score in this box.
## PAST MEDICAL/SURGICAL HISTORY

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

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<th>Condition</th>
<th>Diet controlled</th>
<th>Medication controlled</th>
<th>Insulin controlled</th>
<th>High blood pressure</th>
<th>Chest pain/angina</th>
<th>Heart attack, Date</th>
<th>Valve disease</th>
<th>Cancer/Tumor</th>
<th>Heart disease</th>
<th>Stroke</th>
<th>Circulation problems</th>
<th>Ulcers</th>
<th>Lung disease including emphysema</th>
<th>Stroke</th>
<th>Other</th>
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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.

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<th>Date</th>
<th>Place</th>
<th>Surgeon</th>
<th>Procedure</th>
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Have you had any other surgery besides spine?
- A. No
- B. Yes: Please list below

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<th>Date</th>
<th>Procedure</th>
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CURRENT MEDICATIONS

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<th>Name</th>
<th>Dose</th>
<th>For what problem?</th>
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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:
- Weight gain ✔️
- Weight loss ❌
- Fever ✔️
- Chills ❌
- Night sweats ✔️

Skin:
- Change in moles ✔️
- Breasts lumps ❌

Eyes:
- Loss of vision ❌
- Double vision ✔️

ENT:
- Hearing loss ✔️
- Nose bleeds ❌

GI:
- Nausea ✔️
- Vomiting ✔️
- Change in bowel habits ❌
- Heartburn ❌

Respiratory:
- Shortness of breath ✔️
- Coughing/wheezing ✔️

Heart:
- Chest pain ✔️
- Palpitations ✔️
- Palpitations ❌

GU:
- Frequent urination ✔️
- Difficulty with urination ✔️
- Blood in urine ✔️

Vascular:
- Swelling lower extremities ✔️
- Embol (blood clots) ✔️

Musculoskeletal:
- Muscle weakness ✔️
- Stiffness ✔️
- Joint pain ✔️

Psych:
- Anxiety ✔️
- Depression ✔️
- Confusion ✔️
- Memory loss ✔️

Dr. signature ________________________________
PREFERRED PHARMACY INFORMATION

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<th>City, State, Zip</th>
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Everything I have answered is true and correct to the best of my knowledge.

Patient Signature: ___________________________ Date: ____________

12/26/2012