University of Rochester Physicians Spine Center–New Patient History

Please answer all of the following questions in as much detail as possible. You may select **more than one answer per question.** Feel free to **add additional information** in the margins. Please note that **each page is double-sided.** This information will help in getting an accurate appraisal of your problems and develop an appropriate plan of treatment. If you have any questions or difficulty, please ask for assistance. **Thank you** for taking your time to fill this out completely.

What is your occupation? ___________________________

What happened to cause your injury or pain?

____

____

____

____

____

____

What is your chief complaint?

[ ] Neck Pain
[ ] Upper Back Pain
[ ] Lower Back Pain
[ ] Right Leg Pain
[ ] Left Leg Pain
[ ] Pain in Both Legs
[ ] Right Arm Pain
[ ] Left Arm Pain
[ ] Pain in Both Arms
[ ] Scoliosis
[ ] Other - Specify _____________________

How did the injury occur?

[ ] None/Spontaneous Onset
[ ] Motor Vehicle Accident - No Lawsuit
[ ] Motor Vehicle Accident - Lawsuit Pending
[ ] Motor Vehicle Accident - Lawsuit Complete
[ ] Fall
[ ] Sports or Recreation
[ ] Job Related
[ ] Other – Specify______________

Was the injury job related?

[ ] Yes
[ ] No

If motor vehicle accident, were you?

[ ] Driver
[ ] Front Seat Passenger
[ ] Rear Seat Passenger
[ ] Motorcycle Driver
[ ] Motorcycle Passenger
[ ] Truck Driver
[ ] Truck Passenger
[ ] Other – Specify______________

Were you wearing a seatbelt?

[ ] Yes
[ ] No

Other injuries:

[ ] Head
[ ] Chest
[ ] Extremities, Fracture
[ ] Extremities, No Fracture
[ ] Abdominal
[ ] Other – Specify_____________________
[ ] None

Did the pain start immediately or was there a delayed onset?

[ ] Immediate
[ ] Delayed 1-4 days
[ ] Delayed 1-2 weeks
[ ] Delayed 2-4 weeks
[ ] Delayed 4-8 weeks

When did the pain start?____________________
Month/Day/Year

Since the pain/condition began has it:

[ ] Improved
[ ] Not changed
[ ] Continued to come and go
[ ] Worsened

Do you participate in sports or athletics?

[ ] Regularly 3x/week
[ ] Regularly 2x/week
[ ] Regularly 1x/week
[ ] Irregularly
[ ] None
[ ] Medical Problems Prevent

What aggravates the pain?

[ ] Walking
[ ] Standing
[ ] Sitting
[ ] Lying down
[ ] Bending Forward
[ ] Bending Backwards
[ ] Twisting
[ ] Lifting
[ ] Nothing in particular

What makes the pain better?

[ ] Sitting
[ ] Lying down
[ ] Walking
[ ] Standing
[ ] Leaning Forward or a Shopping Cart
[ ] Nothing in particular

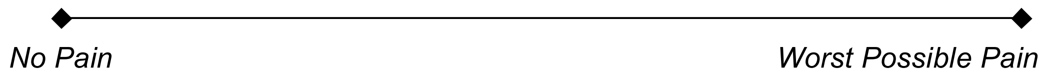
Check all that apply, then

Please circle any of these that were helpful in relieving your pain (or circle 'nothing').

[ ] nothing
[ ] Physical therapy
[ ] active exercise
[ ] TENS unit
[ ] heat
[ ] cold
[ ] manipulation
[ ] Spinal injections
[ ] surgery
[ ] pain psychology
[ ] holistic or alternative treatments
[ ] Chiropractor
[ ] Medication
[ ] Other – Specify_____________________

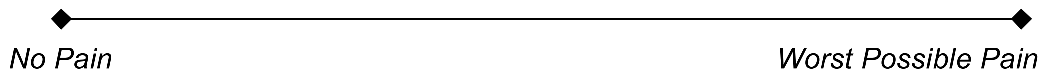
The following lines represent pain of increasing intensity from "no pain" to "very severe pain." Draw ONE vertical mark on each of the lines below to best describe:

Your pain right now:



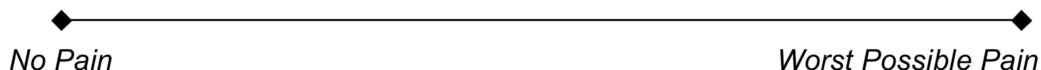
No Pain *Worst Possible Pain*

The average intensity of your pain this week:



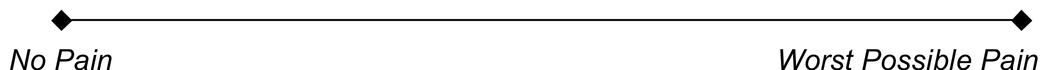
No Pain *Worst Possible Pain*

Your pain at its worst:



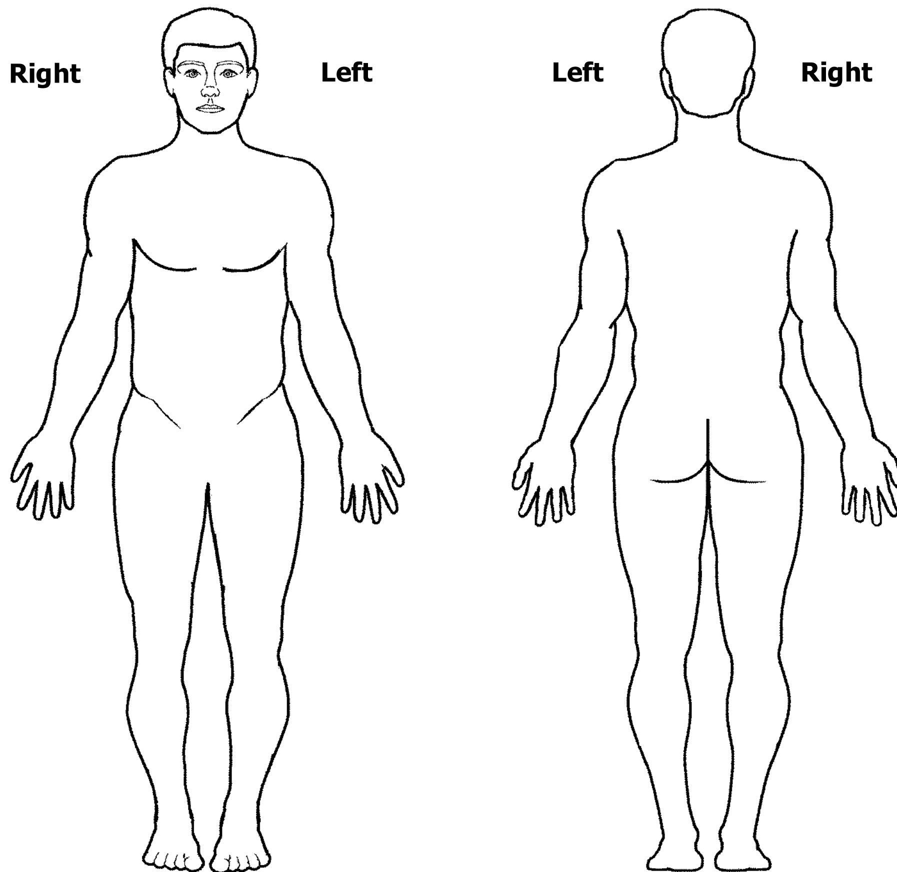
No Pain *Worst Possible Pain*

Your pain at its least:



No Pain *Worst Possible Pain*

On the drawings below, please shade the area where you currently experience pain.



The following questions are about activities you might do during a typical day. Does your back problem now limit you in these activities? If so, how much? Check only one answer for each activity.

	No, not limited at all	**Yes, limited a little**	**Yes, limited a lot**
Vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports	[ ]	[ ]	[ ]
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	[ ]	[ ]	[ ]
Lifting or carrying groceries	[ ]	[ ]	[ ]
Climbing several flights of stairs	[ ]	[ ]	[ ]
Climbing one flight of stairs	[ ]	[ ]	[ ]
Bending, kneeling, or stooping	[ ]	[ ]	[ ]
Walking more than one mile	[ ]	[ ]	[ ]
Walking several blocks	[ ]	[ ]	[ ]
Walking one block	[ ]	[ ]	[ ]
Bathing or dressing yourself	[ ]	[ ]	[ ]

Choose one response option for each activity.

	Not difficult at all	Minimally Difficult	Somewhat difficult	Fairly difficult	Very Difficult	Unable to do
Turn over in bed	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Ride in a car	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sit in a chair for several hours	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Lift and carry a heavy suitcase	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

The following questions are designed to give the doctor information as to how your spine(back) pain has affected your ability to manage in everyday life. **Please answer every section, and choose only the __one__ box that applies to you.** Sometimes two of the statements in one section seem right, but please just mark the box that most closely describes your problem.

Section 1 – Pain Intensity (choose only one)
[ ] I can tolerate the pain without having to use painkillers.
[ ] The pain is bad but I manage without 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 pain and I don't use them.

Section 2 – Personal Care (choose only one)
[ ] I can look after myself normally without causing extra pain.
[ ] I can look after myself normally but it causes me 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, wash with difficulty, and stay in bed.

Section 3 – Lifting (choose only one)
[ ] 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, e.g. 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 only very light weights.
[ ] I cannot lift or carry anything at all.

Section 4 – Walking (choose only one)
[ ] Pain does not prevent me walking any distance.
[ ] Pain prevents me from walking for more than 1 mile.
[ ] Pain prevents me from walking for more than ½ mile.
[ ] Pain prevents me from walking for more than ¼ 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 (choose only one)
[ ] I can sit in any chair as long as I like.
[ ] I can sit in my favorite chair as long as I like.
[ ] Pain prevents me from sitting more than 1 hour.
[ ] Pain prevents me from sitting more than ½ hour.
[ ] Pain prevents me from sitting for more than 10 minutes.
[ ] Pain prevents me from sitting at all.

Section 6 – Standing (choose only one)
[ ] I can stand as long as I want without extra pain.
[ ] I can stand as long as I want, but it gives me extra pain.
[ ] Pain prevents me from standing for more than 1 hour.
[ ] Pain prevents me from standing for more than 30 minutes.
[ ] Pain prevents me from standing for more than 10 minutes.
[ ] Pain prevents me from standing at all.

Section 7 – Sleeping (choose only one)
[ ] 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 – Sex Life (choose only one)
[ ] My sex life is normal and causes no extra pain.
[ ] My sex life is normal, but causes some extra pain.
[ ] My sex life is nearly normal, but is very painful.
[ ] My sex life is severely restricted by pain.
[ ] My sex life is nearly absent because of pain.
[ ] Pain prevents any sex life at all.

Section 9 – Social Life (choose only one)
[ ] 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, etc
[ ] 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 10 – Traveling (choose only one)
[ ] 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 two hours.
[ ] Pain restricts me to journeys of less than 1 hour.
[ ] Pain restricts me to journeys of less than 30 minutes.
[ ] Pain prevents me from traveling, except to the doctor or hospital.

Do you have any problems with bowel, bladder, or sexual functions?
[ ] None
[ ] No problems except for occasional constipation
[ ] Difficulty controlling bladder functions
[ ] History of urinary tract infections
[ ] Sexual problems secondary to pain
[ ] Physical problems with sexual function other than pain
[ ] Other - Specify ____________________

Do you have any difficulty walking?
[ ] No
[ ] Yes, can walk less than a mile
[ ] Yes, can walk only 1-2 blocks
[ ] Yes, can walk unlimited distance
[ ] Yes, non-ambulatory

Are you right or left handed?
[ ] Right handed
[ ] Left handed
[ ] Ambidextrous

Are you:
[ ] married
[ ] single
[ ] divorced
[ ] widow/widower
[ ] separated
[ ] other_________

With whom do you live?
[ ] living with spouse
[ ] living alone
[ ] living with children
[ ] living with parents
[ ] living in a community
[ ] other____________

What is the highest grade you completed or degree you received? ___________________

What is your current work status?
[ ] Regular Employment - No Restrictions
[ ] Full - Time with Restrictions
[ ] Part - Time by Choice
[ ] Part - Time for Medical Reasons
[ ] Retired by Choice
[ ] Retired by Medical Reasons
[ ] Unemployed - Looking for work with no restrictions
[ ] Unemployed - Looking for light duty
[ ] Unemployed
[ ] Currently not working for medical reasons
[ ] Student
[ ] Other – Specify____________________

Have you attempted to return to work since the onset of your pain?
[ ] Yes – When did you attempt this return?____________________
[ ] No
[ ] This does not apply to me.

When did you last work?____________________

Please mark all of the following that apply to you.

Constitutional
- [ ] Low fever
- [ ] High fever
- [ ] Chills
- [ ] Loss of appetite
- [ ] Unexplained weight loss
- [ ] Unusual tiredness
- [ ] Insomnia
- [ ] Sedation

Eyes
- [ ] blurred vision
- [ ] double vision
- [ ] abnormal vision
- [ ] glasses
- [ ] contact lenses

Ears, Nose, Mouth, Throat
- [ ] ringing in ears
- [ ] room spinning
- [ ] dizziness
- [ ] sinus pain
- [ ] sinus drainage
- [ ] mouth sores
- [ ] sore throat

Cardiovascular
- [ ] high blood pressure
- [ ] angina (chest pain)
- [ ] trouble breathing
- [ ] trouble breathing when flat
- [ ] ankle swelling
- [ ] heart attack
- [ ] congestive heart failure
- [ ] mitral valve prolapse
- [ ] abnormal heart rhythm
- [ ] heart murmur

Respiratory
- [ ] heavy cough
- [ ] cough up sputum
- [ ] cough up blood
- [ ] pneumonia
- [ ] asthma

Neurological
- [ ] fainting
- [ ] epilepsy (seizures)
- [ ] stroke
- [ ] memory problems

Gastrointestinal
- [ ] nausea
- [ ] stomach pain
- [ ] vomiting
- [ ] vomiting blood
- [ ] vomiting "coffee grounds"
- [ ] ulcers
- [ ] hiatal hernia
- [ ] constipation
- [ ] diarrhea
- [ ] change in bowel habits
- [ ] blood in stool
- [ ] black, tarry stools

Genitourinary
- [ ] painful urination
- [ ] blood in urine
- [ ] vaginal discharge
- [ ] discharge from penis
- [ ] impotence
- [ ] loss of sexual desire
- [ ] painful sex
- [ ] kidney problems
- [ ] one kidney
- [ ] kidney failure
- [ ] dialysis
- [ ] kidney transplant
- [ ] venereal disease
- [ ] change in bladder habits
- [ ] urgency
- [ ] hesitancy

Date of last menstrual period:
____

Musculoskeletal
- [ ] painful joints
- [ ] swollen joints
- [ ] redness of joints
- [ ] joint infection
- [ ] bone infection
- [ ] gout
- [ ] osteoarthritis
- [ ] rheumatoid arthritis
- [ ] ankylosing spondylitis
- [ ] osteoporosis
- [ ] osteomalacia
- [ ] sore muscles
- [ ] muscle spasms

Integumentary (Skin)
- [ ] Skin Sores
- [ ] Skin Rash
- [ ] Itching
- [ ] Skin Cancer

Psychiatric
- [ ] depression
- [ ] want to die
- [ ] anxiety

Endocrine
- [ ] diabetes
- [ ] thyroid (too little)
- [ ] thyroid (too much)

Hematologic/Lymphatic
- [ ] unusual sweating
- [ ] unusual bleeding
- [ ] easy bruising
- [ ] mass (lumps or bumps)
- [ ] breast lump
- [ ] swollen glands
- [ ] anemia
- [ ] infection
- [ ] HIV
- [ ] AIDS
- [ ] hepatitis
- [ ] cancer_______________

what type?

Other Medical Problems:

Do any of your blood relatives have any of these diseases?
- [ ] None
- [ ] Back or Neck Problems
- [ ] Rheumatoid Arthritis
- [ ] Cancer
- [ ] Coronary Artery Disease
- [ ] high blood pressure
- [ ] lung problems
- [ ] diabetes
- [ ] kidney problems
- [ ] ulcers
- [ ] heart problems
- [ ] gout
- [ ] epilepsy (seizures)
- [ ] stroke
- [ ] thyroid (too little)
- [ ] thyroid (too much)
- [ ] anemia
- [ ] Other – Specify_______

Do you have any allergies? **Are you allergic to latex?: [ ]Yes [ ]No**

[ ] No

[ ] Yes, please list:____

Do you **Smoke, chew tobacco, or dip snuff**? If yes, how much per day and for how long?

[ ] Yes ______ packs/cans _______ years

[ ] No

Did you ever smoke, chew tobacco, or dip snuff regularly? If yes, how much per day and for how long?

[ ] Yes ______ packs/cans _______ years

[ ] No

When did you last smoke/chew/dip (month/day/year)? _______________

How much alcohol do you consume in an average week?

[ ] None

[ ] Less than 6 drinks (beer, wine, etc.)

[ ] 6-12 drinks

[ ] 12-24 drinks

[ ] 24-48 drinks

[ ] More than 48 drinks

Current Medications–

What medications are you currently taking, and for what medical problem? See List [ ]

Name: *Dosage:* *Frequency:* *Notes:*

____

____

____

____

____

____

____

____

____

____

____

____

Have you ever had other episodes or injuries with your neck or back?

[ ] No, never

[ ] Yes, one → This episode or injury was in ____________________ (*year*).

[ ] Yes, more than one → The first episode or injury was in ____________________ (*year*).

The last episode or injury was in ____________________ (*year*).

Total number of episodes or injuries:________________________.

Frequency of these episodes or injuries:

[ ] more than once a week

[ ] once a week

[ ] once a month

[ ] once a quarter (every three months)

[ ] once a year

[ ] less than once a year

Have you ever been involved in any legal proceedings related to **this** health matter?

[ ] No

[ ] Yes

[ ] disability or social security

[ ] workman's compensation

[ ] a motor vehicle crash

[ ] medical malpractice

[ ] other legal proceedings, *please describe*:_______________________

Have you ever been involved in any legal proceedings related to a **previous** health matter?

[ ] No

[ ] Yes

[ ] disability or social security

[ ] workman's compensation

[ ] a motor vehicle crash

[ ] medical malpractice

[ ] other legal proceedings, *please describe*:_______________________

Have you had any previous neck or back(**spine**) surgery?

[ ] Yes, one

[ ] Yes, two

[ ] Yes, three

[ ] Yes, four

[ ] Yes, five

[ ] Yes, six

[ ] Yes, seven

[ ] Yes, eight

[ ] Yes, nine

[ ] No

Please list your previous neck and back(**spine**) operations:

Date: Place: Surgeon: Procedure:

____

____

____

____

____

What surgery have you had **other than spine or back surgery**?

Date: Place: Surgeon: Procedure:

____

____

____

____

____

____

Have you had any of the following complications of surgery?

[ ] Bleeding
[ ] Infection
[ ] Poor Wound Healing
[ ] Other – Specify________________________________

Thank you for completing this questionnaire!

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Height:________________INCHES Weight:______________

BP:_________/_________ Pulse:__________Respiration:_______

Revised 09/04