

Name:  
DOB:  
Chart:  
Age:  
Date:



## SPINE QUESTIONNAIRE

DATE \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WHO REFERRED YOU HERE? \_\_\_\_\_

WHEN DID YOUR PRESENT PAIN START? \_\_\_\_\_

WHAT WERE YOU DOING WHEN IT STARTED? \_\_\_\_\_

HAVE YOU EVER INJURED YOUR BACK OR NECK BEFORE? \_\_\_\_\_

HAVE YOU EVER HAD BACK OR NECK PAIN BEFORE? \_\_\_\_\_

MY PAIN IS: (CHECK THE APPROPRIATE BOX)

	<b>Better</b>	<b>Worse</b>	<b>No Different</b>
With cough or sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting in a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on my back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on my side with my knees bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ON A SCALE OF 0-10 (0 BEING NO PAIN AND 10 BEING SEVERE PAIN):

HOW WOULD YOU RATE YOUR PAIN IN YOUR:

Back \_\_\_\_\_ Right Leg \_\_\_\_\_ Left Leg \_\_\_\_\_

Neck \_\_\_\_\_ Right Arm \_\_\_\_\_ Left Arm \_\_\_\_\_

NAME ALL THE DOCTORS WHO HAVE TREATED YOU FOR THIS \_\_\_\_\_

HAVE YOU EVER HAD AN EPIDURAL BLOCK? \_\_\_\_\_ WHEN \_\_\_\_\_ DID IT HELP \_\_\_\_\_

HAVE YOU EVER HAD A FACET BLOCK? \_\_\_\_\_ WHEN \_\_\_\_\_ DID IT HELP \_\_\_\_\_

WHAT OTHER TREATMENTS HAVE BEEN USED? (CHECK THOSE THAT APPLY)

MEDICINE  BRACE  PHYSICAL THERAPY  MANIPULATION

HAVE YOU EVER HAD BACK SURGERY? DATE \_\_\_\_\_ DOCTOR \_\_\_\_\_

HAVE YOU EVER HAD NECK SURGERY? DATE \_\_\_\_\_ DOCTOR \_\_\_\_\_

HAVE YOU EVER MISSED WORK DUE TO THIS PROBLEM? \_\_\_\_\_ IF SO, WHEN \_\_\_\_\_  
AND HOW LONG? \_\_\_\_\_

DO YOU HAVE AN INCONTINENCE PROBLEM? \_\_\_\_\_

HAS YOUR SEXUAL ACTIVITY BEEN EFFECTED? \_\_\_\_\_

HAS YOUR BACK OR NECK BEEN X-RAYED? \_\_\_\_\_ WHEN \_\_\_\_\_ WHERE \_\_\_\_\_

HAVE YOU EVER HAD A MRI OF THE BACK? \_\_\_\_\_ DATE \_\_\_\_\_ WHERE \_\_\_\_\_

HAVE YOU EVER HAD A MRI OF THE NECK? \_\_\_\_\_ DATE \_\_\_\_\_ WHERE \_\_\_\_\_

PLEASE ADD ANYTHING THAT YOU FEEL IS IMPORTANT \_\_\_\_\_

DO YOU HAVE AN ATTORNEY HELPING YOU? \_\_\_\_\_

Name:  
 DOB:  
 Chart:  
 Age:  
 Date:

PLACE AN "X" ON THE PICTURE WHERE YOU HAVE PAIN

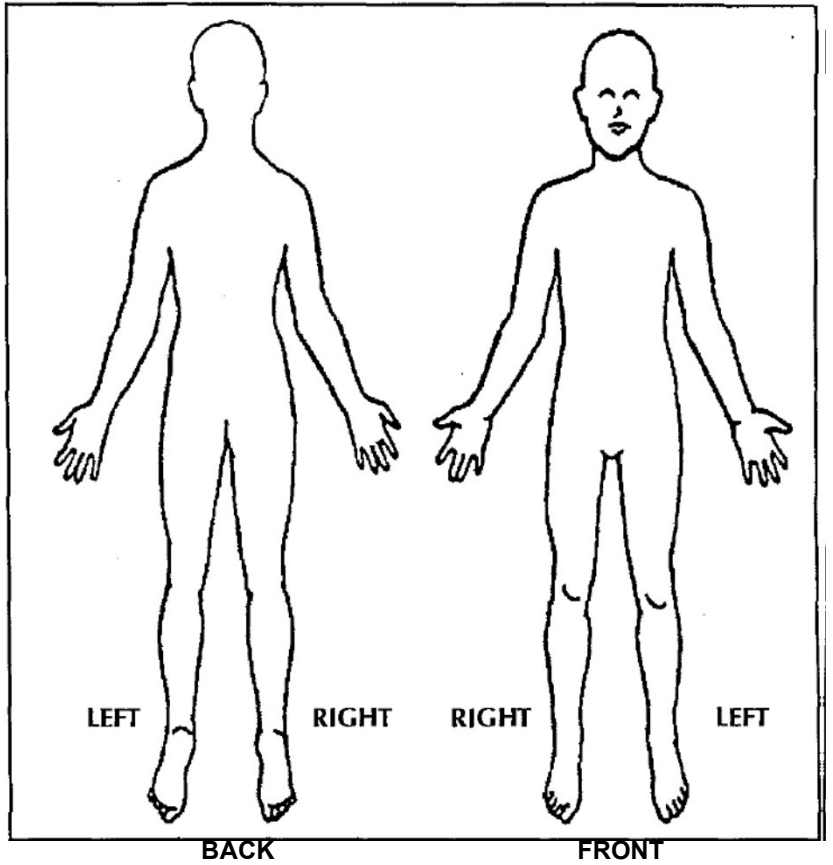
PLACE AN "O" ON THE PICTURE WHERE YOU HAVE NUMBNESS AND TINGLING

DIVIDE THE TOTAL AMOUNT OF PAIN BETWEEN YOUR SPINE AND EXTREMITY: = 100%

\_\_\_\_\_ % BACK PAIN  
 \_\_\_\_\_ % LEG PAIN

OR

\_\_\_\_\_ % NECK PAIN  
 \_\_\_\_\_ % ARM PAIN



**DO NOT WRITE BELOW THIS SPACE**

**STAND**      HABITUS      LIST      LIGHT TOUCH  
                  SPASM

FORWARD FLEX \_\_\_\_\_ HAND TO FLOOR \_\_\_\_\_

EXTENSION \_\_\_\_\_ REVERSE LORDOTIC CURVE \_\_\_\_\_

PAIN GREATER:    FLEX \_\_\_\_\_ EXT \_\_\_\_\_ SAME \_\_\_\_\_

HEEL AND TOE WALK \_\_\_\_\_ GIVE AWAY \_\_\_\_\_

**SIT**      MOTOR      PARASTHESIAS      STOCKING-NONDERMATOMAL  
                  REFLEX      SENSORY  
                  LTS      STRETCH

SUPINE    STRETCH RIGHT \_\_\_\_\_ PFELX \_\_\_\_\_  
                  LEFT \_\_\_\_\_ PFELX \_\_\_\_\_

WADDELL      TENDER  
 SIMULATION-AXIAL      DISTRACTION-SLR  
 REGIONAL      OVERT