OrthoTexas Physicians and Surgeons – Patient Questionnaire

Please print off, complete by hand and bring with you to your appointment.

Name: _____ Date: _____

DOB: _____

1. Select ONE as your primary symptom.
    1. Low back pain
    2. Mid back pain
    3. Neck pain
    4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
    5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
    6. Arm pain, numbness or tingling. Left Right or Both
    7. Shoulder pain Left Right or Both
    8. Headache
    9. Other _____

2. In addition to your primary symptom noted above, what OTHER symptoms do you have?
    1. Low back pain
    2. Mid back pain
    3. Neck pain
    4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
    5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
    6. Arm pain, numbness or tingling. Left Right or Both
    7. Shoulder pain Left Right or Both
    8. Headache
    9. Other _____

3. What was the onset date of your symptoms or your injury? _____

4. Are your symptoms related to a Motor Vehicle Accident (MVA)? Yes No
    If Yes, Date(s): _____

5. Are your symptoms recognized as a workers compensation injury? Yes No Undetermined

    Please explain _____

    _____

6. Work History: Current occupation _____
Employer _____
Are you currently working? Yes No
Physical demands of work: ____Sedentary ____Mild ____Moderate ____Heavy
Have you missed work due to your current symptoms? Yes No Please explain
_____
Have you been given work restrictions by your physician? Yes No Please list
_____
_____
Have you been given a workers compensation disability rating in the past for your Spine symptoms? Yes No What was the rating? _____
By whom? _____
Don't know _____

7. Place an X by the treatments or diagnostic tests you have had for your spine symptoms.
____ Medications What type? Anti-inflammatory, Muscle relaxant, Medrol Dose Pack, Prednisone, Pain Medications, other _____
____ Physical Therapy (date) _____
____ Chiropractic care (date) _____
____ Massage
____ X-Ray (date) _____
____ CT Scan (date) _____
____ MRI Scan (date) _____
____ Myelogram (date) _____
____ EMG (date) _____
____ Epidural steroid injection (date) _____
____ Diagnostic nerve block (date) _____
____ Other _____

8. Have you been referred to any other specialists for evaluation of your spine symptoms?

Yes No Please list _____

9. Have you had surgery on your **NECK**? Yes No
Date of most recent **Neck** Surgery _____

Name of Surgeon: _____

What type of NECK surgery:
____Discectomy
____Microdiscectomy
____Laminectomy
____Fusion
____Other _____

On your **BACK**? Yes No
Date of most recent **Back** Surgery _____

Name of Surgeon: _____

What type of BACK surgery:
____Discectomy
____Microdiscectomy
____Laminectomy
____Fusion
____Other _____

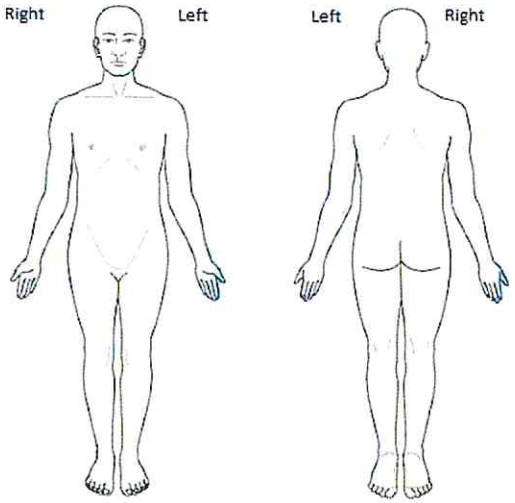
10. Symptom Assessment: Please rate your CURRENT symptoms: (0=no pain, 10=severe)

With regard to your Neck: 0 1 2 3 4 5 6 7 8 9 10

With regard to your Back: 0 1 2 3 4 5 6 7 8 9 10

11. Mark these drawings according to where you hurt. Please indicate which sensation you feel by referring to the key below.

Key: Stabbing /// Burning XXX Pins & Needles 000 Numbness === Aching +++



12. Please note if the following improve or worsen your symptoms.

Improve	Worsen	Unchanged		Improve	Worsen	Unchanged	
_____	_____	_____	Sitting	_____	_____	_____	Laying Down
_____	_____	_____	Standing	_____	_____	_____	Computer/Desk work
_____	_____	_____	Walking	_____	_____	_____	Cough/Sneeze/Strain
_____	_____	_____	Bending	_____	_____	_____	Lifting

13. Is this your first episode of pain or have you had recurrent episodes? First episode: Yes No
Recurrent, how many? _____ Date of Most Recent Episode: _____

14. Please rate the quality of your sleep ____ Poor ____ Fair ____ Good ____ Excellent

What goals or results do you wish to achieve by the end of your rehab here at OrthoTexas?

_____

Thank you for completing the OrthoTexas Spine Questionnaire.

Comments _____

Patient Signature: _____ Date: _____