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Welcome to the Spine Ortho Clinic. Please take a few minutes to complete the attached questionnaire. Having this information completed gives us the best chance to accurately diagnose and treat your problems.

Name: _____ Age: _____

Height: _____ Weight: _____ Hand dominance: ☐ Right ☐ Left ☐ None

Family Physician: _____

Reason for today's visit: _____

Date of Injury or when you first noticed your symptoms: _____

Please describe the injury or events leading to the onset of your symptoms: _____

_____

_____

Please describe the evolution of your symptoms since their onset: _____

_____

_____

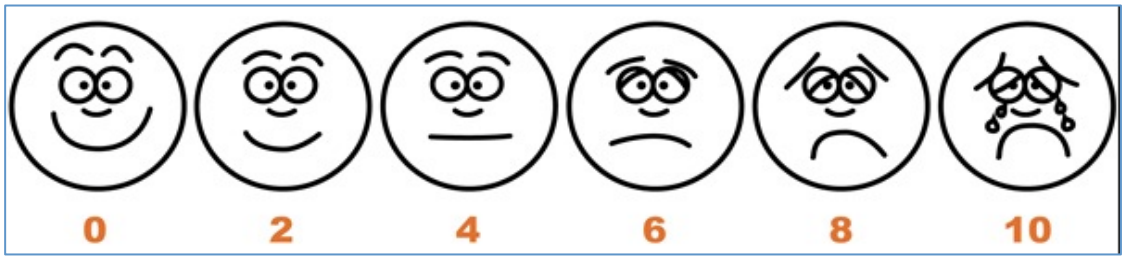
What questions would you like to have answered during your visit today? _____

_____

_____

Since the onset of your problem, are you: ☐ getting better ☐getting worse ☐staying the same

Please rate your pain on a scale of 0-10 (0 = no pain, 10 = worst pain imaginable): _____



In percentages, how much of your pain is located centrally in your back or neck and how much radiates out to your legs and arms?

___ % in my back or neck + ___ % in my legs or arms = 100%

What are the characteristics of your pain?

☐ Aching ☐ Throbbing ☐ Electrical ☐ Muscle Cramp ☐ Dull ☐ Sharp

What makes your symptoms **better**? _____

What makes your symptoms **worse**? _____

What medication(s) are you **currently** taking for the pain? _____

Over the last month, how often have you taken medication for the pain?

☐ 3 or 4 times a day ☐ 1 or 2 times a day ☐ Once every few days

☐ Once a week ☐ Once every few weeks ☐ Not at all

Describe any part of your body that is **numb**: _____

Describe any party of your body that is **weak**: _____

What does your problem limit you from doing: _____

How far can you walk comfortably? ☐ Around the home only ☐ A few blocks ☐ Less than a kilometre

☐ About a kilometre ☐ A few kilometres ☐ No limitations

Please check and list the approximate date of any diagnostic test you have had performed on your spine:

☐ X-Rays ☐ MRI ☐ EMG ☐ CT scan or Myleogram ☐Bone Scan ☐ Discogram

☐ Other, please specify: _____

What treatments have you tried?

Treatment	Was it Helpful?	Number of Treatments	Date of most recent Treatment
Physical Therapy			
Acupuncture			
Chiropractor			
Injections			
Massage			

Have you had surgery on your spine? ☐ Yes ☐ No

Date	Surgeon	Surgical Procedure

Do you have any medical problems? (Please mark the individual problems)

☐Yes ☐No History of blood clots

☐Yes ☐No Cancer (type _____)

☐Yes ☐No Chemical dependency or alcohol

☐Yes ☐No Diabetes

☐Yes ☐No Heart Disease

☐Yes ☐No Fibromyalgia

☐Yes ☐No Hepatitis

☐Yes ☐No HIV

☐Yes ☐No Hypertension

☐Yes ☐No Hypercholesterolemia

☐Yes ☐No Hypothyroidism

☐Yes ☐No Kidney Failure

☐Yes ☐No Osteoporosis

☐Yes ☐No Rheumatoid Arthritis

Other, Please specify : _____

Please check and list the approximate dates, if any, that you have had any of the following surgeries:

☐ Heart surgery ☐ Lung surgery ☐ Appendectomy ☐ Hernia Repair

Other, please specify: _____

Please describe if you have any health problems with any of the following areas:

Fever or Weight Loss	
Eye, Ear, Nose or Throat	
Heart Problem	
Breathing / Lung Problems	
Stomach / Intestinal Problems	
Kidney / Liver Problems	
Skin Conditions	
Urinary Problems	
Infections	
Bleeding Problems	
Neurological Problems	
Psychiatric Problems	

Please list any medications to which you have an allergy to and the reaction the medication causes:

Medication	***Reaction***

Please list ALL medications that you are currently taking, the dosage and the reason for taking each medication:

Medication	***Dosage (amount & frequency)***	***Reason***

Please check and list the relationship if a family member has problems with the following:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Kidney Problems ☐ Hypertension ☐ Stroke

☐ Arthritis ☐ Scoliosis ☐ Other (Please describe) _____

Do you smoke? ☐ No, I have never smoked. ☐ Yes, I have smoked for ____ years.

☐ No, I quit on (date) _____ and I smoked for a total of ____ years.

How much do (or did) you smoke on most days? _____ cigarettes a day.

How much alcohol do you drink on an average week? ☐ None ☐ 4 or more drinks daily

☐ 2 or 3 drinks daily ☐ 1 drink daily ☐ A few drinks a week ☐ 1 drink a week or less

Have you retained a solicitor because of your spine problem? ☐ No

☐ Yes, settled lawsuit ☐ Yes, pending lawsuit ☐ Yes, case status unknown

Please check the following that best describes your current employment: ☐ Employed Full-time ☐ Employed Part-Time

☐ Unemployed ☐ Disabled ☐ Workers Compensation ☐ Retired ☐ Homemaker ☐ Student

Answer the following based on your current employment or last employment, if not working:

Occupation: _____ Average number of hours a week you work(worked): _____

Please describe the physical requirements of your work:

_____

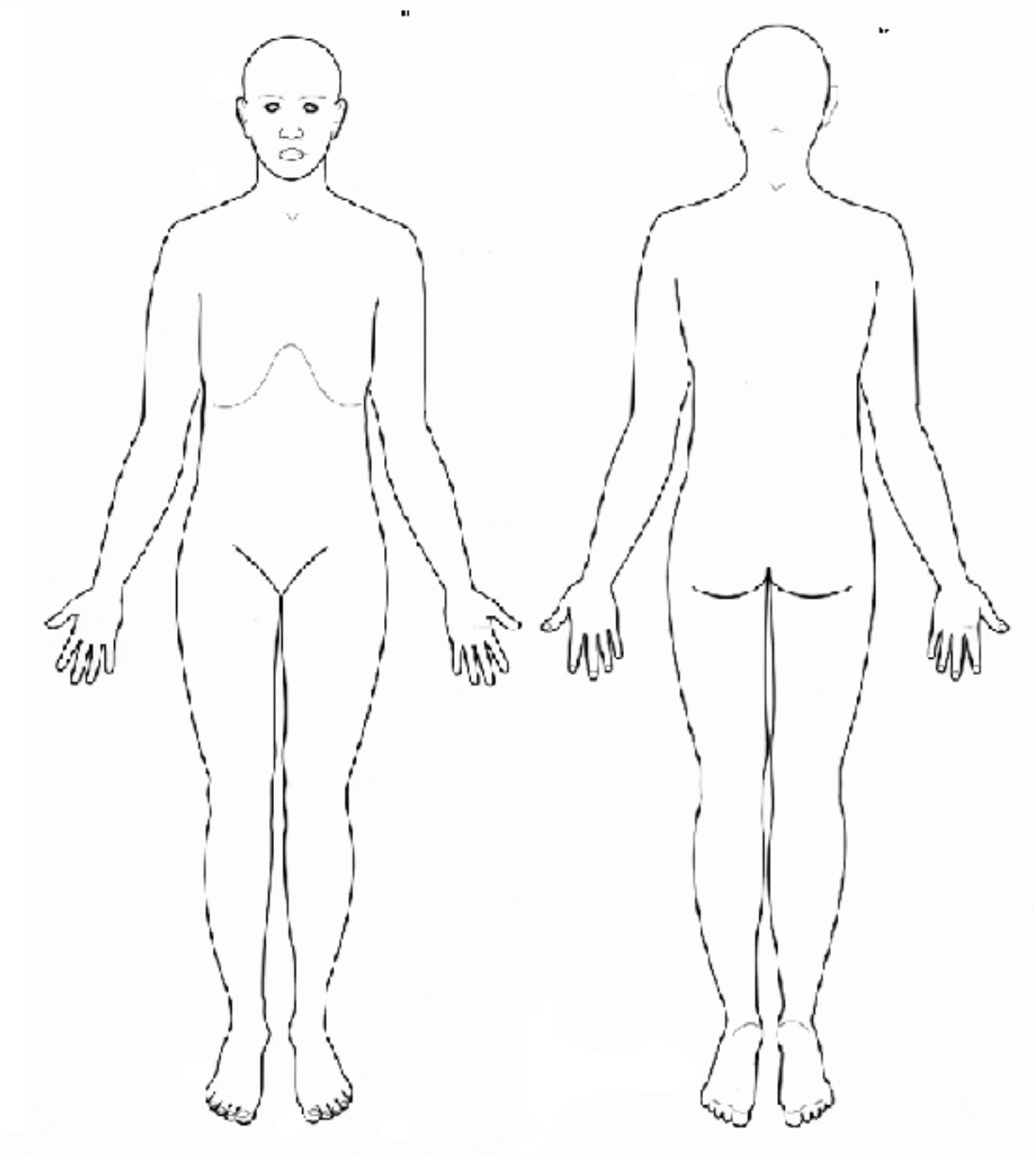
_____

_____

Pain Diagram

Mark the areas of your body where you feel the described sensation.
Use the appropriate symbol.
Mark all the areas, including the areas of radiation.

PAIN: XXXX
NUMBNESS: 0000
TINGLING: IIII



FRONT **BACK**

Right **Left** **Left** **Right**

OSWESTRY DISABILITY INDEX FOR BACK

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 pain at the moment.

Section 2 – Personal Care (washing, dressing etc.)

- ☐ I can look after myself normally and it is not very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 my personal 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 me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ie on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than a kilometre.
- ☐ Pain prevents me walking more than ½ kilometre.
- ☐ Pain prevents me walking more than 100 metres.
- ☐ 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 sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Name: _____

Date: _____

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 me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ☐ 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

- ☐ My social life is normal and causes 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, ie. Sports.
- ☐ 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 the pain.

Section 10 – Travelling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ The pain is bad but I manage journeys of over 2 hours.
- ☐ The pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from travelling except to receive treatment..

Section 11 – Previous Treatment

Over the past three months, have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box:

- ☐ No
- ☐ Yes *(if yes, please state the type of treatment you have received)*

……

……

……

OSWESTRY DISABILITY INDEX FOR Neck

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 pain at the moment.

Section 2 – Personal Care (washing, dressing etc.)

- ☐ I can look after myself normally and it is not very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ 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 my personal 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 me 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 only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly 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 that come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all of the time.

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 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 can 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 neck pain.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive 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 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours 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 recreational activities because of the pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of the pain in my neck.
- ☐ I can hardly do any recreational activities because of the pain in my neck.
- ☐ I cannot do any recreational activities at all.

Name: _____

Date: _____