UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER
SPINE INSTITUTE

Spinal Questionnaire

Please Complete ***ALL 6*** pages of the form
in blue/black ink.

Patient's Name: _____ Date: _____

Email Address: _____ Age: _____ Date of Birth: _____

Patient's Address: _____ SS#: _____

Home Phone#: _____ Cell#: _____ Work#: _____

Employer: _____ Emergency contact/phone#: _____

Which Medical Provider Referred You to Us? _____

Primary Care Physician Name & Phone#: _____

Sex: ☐ Male ☐ Female Are you: ☐ Right Handed ☐ Left Handed

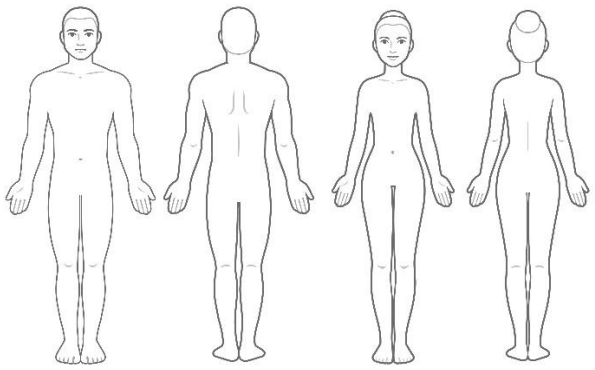
What is your main problem(s) for which you are seeking treatment at the Spine Center: _____

_____

_____

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins and Needles	Burning	Stabbing	Aching
===	ooo	xxx	///	***



Please place an "X" on the line below indicating how bad your pain is now:

No Pain ----------Worst Possible Pain
0 10

Spine Questionnaire

(Continued)

1. **When did your present pain start (approximate date)? _____**
2. **Have you had similar pains in the past? ☐ no ☐ yes If yes, when? _____**
3. **How did your pain start? (Please check all that apply to you.)**

   ☐ Suddenly ☐ Lifting ☐ Bending ☐ Fall ☐ No apparent cause
   ☐ Gradually ☐ Twisting ☐ Pulling ☐ Accident
4. **What activities make your pain worse? (Please check ALL that apply to you)**

   ☐ Lying ☐ Standing ☐Exercise (during) ☐ Bending Forward ☐ Twisting
   ☐ Sitting ☐Walking ☐ Exercise(after) ☐ Bending Backward ☐ Coughing/Sneezing
5. **What reduces your pain? (Please check ALL that apply to you)**

   ☐ Lying ☐ Standing ☐Exercise (during) ☐ Bending Forward ☐ Twisting
   ☐ Sitting ☐Walking ☐ Exercise(after) ☐ Bending Backward ☐ Coughing/Sneezing
6. **What Medication and dosage either prescription or over the counter are you currently taking for this pain?**

   _____
   _____

   ☐ None
7. **What Treatments have you tried for this current pain?**

   ☐ Physical Therapy ☐ Chiropractic ☐Acupuncture ☐ Home Exercises
   ☐ None
8. **Have you been seen for this current pain by?**

   ☐ MD/NP/PA _____ ☐ Emergency Room date: _____
   ☐ Urgent Care Center date: _____ ☐ Hospitalized date: _____
   ☐ None
9. **Have you had any of the following tests?**

   ☐ X-rays date: _____ ☐MRI date: _____
   ☐ CT scan date: _____ ☐MRI date: _____
   ☐ Other: _____ date: _____
   ☐ None
10. **Have you had surgery for this pain or similar pain? ☐ no ☐ yes**

    if yes, describe the type of surgery you had, when and where performed and the name of the surgeon.

    _____
    _____
11. **Is your pain due to a work-related injury?**
12. **Are you still working?**
13. **Is your pain due to an auto accident injury?**
14. **Is a lawyer involved in your injury?**

    If yes, please provide us with your lawyer's name, address, and phone number.

    _____

Spine Questionnaire

(Continued)

REVIEW OF SYMPTOMS – Please check ALL items that apply to you.

☐ Weight Loss/Gain	☐ Night Sweats	☐ Poor Sleep	☐ Bladder Accidents/Incontinence
☐ Fever	☐ Recent Infections	☐ Fatigue	☐ Mood Changes Agitation/Anxiety
☐ Arm Numbness	☐ Leg Numbness	☐ Muscle Weakness	☐ Bowel Accidents/Incontinence
☐ Stiffness	☐ Swelling	☐ Joint Pain	☐ Bleeding/Bruising Problems
☐ Severe Nighttime Pain	☐ Difficulty Walking	☐ Genital Numbness	☐ Recent Chest Pain
☐ Change in Handwriting Ability	☐ Rashes	☐ Dizziness	☐ Shortness of Breath
☐ Difficulty Buttoning Buttons	☐ Changes in Appetite	☐ Blurred Vision	

☐ Other (describe): _____

PAST MEDICAL HISTORY – Please check ALL items that apply to you.

☐ High Blood Pressure	☐ Thyroid Disease	☐ Psychiatric Illness	☐ Osteoporosis
☐ Heart Disease	☐ Lung Disease	☐ Kidney Disease	☐ Osteoarthritis
☐ Liver Disease	☐ Diabetes	☐ Acid Reflux	☐ Rheumatoid Arthritis
☐ Seizures/Epilepsy	☐ Ulcer	☐ High Cholesterol	☐ None

☐ Cancer (please specify):_____

☐ Other (please specify): _____

PAST SURGICAL HISTORY – Please check ALL items that apply to you.

☐ Lumbar Spine/Low Back	☐ Bowel	☐ Appendectomy	☐ Extremities/Arms or Legs
☐ Kidney	☐ Breast	☐ Lung	☐ C-section
☐ Prostate	☐ Heart	☐ Gallbladder	☐ None
☐ Cervical Spine/Neck	☐ Hernia	☐ Hysterectomy	

☐ Other (please specify): _____

ALLERGIES – Please check ALL items that apply to you and what reaction you had.

☐ Penicillin; reaction_____ ☐ Sulfa; reaction _____

☐ Iodine; reaction _____ ☐ Codeine; reaction_____

☐ Other Medications; reaction _____

☐ None

MEDICATIONS – Please list ALL medications that you are taking as well as the dosages and how often.

_____ _____ _____ _____

_____ _____ _____ _____

FAMILY HISTORY – Please Check any disease diagnosed in your blood relatives

☐ Cancer	☐ Diabetes	☐ Arthritis	☐ Heart Disease
☐ Stroke	☐ Neck/Low Back Pain	☐ High Blood Pressure	

☐ Other: _____

SOCIAL HISORY – Please answer ALL questions

Are You: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Do You Live: ☐ Alone ☐ With Others

Are You: ☐ Employed ☐ Retired ☐ Disabled

What Is(was) Your Occupation? _____

Is Your Job: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy

If Unemployed, how long have you not been working? _____

Do You Smoke? ☐ No ☐ Yes, how much_____

Have you ever smoked: ☐ No ☐Yes, Number of years_____ When Did You Quit? _____

Do You Drink Alcohol: ☐ No ☐Yes, How much/week_____

Do you Use Illegal Drugs: ☐ No ☐Yes, How much/week_____

Highest Level of Education Completed: ☐ GED ☐ High School ☐ College ☐ Graduate School

☐ Other:_____

Spine Questionnaire

(Continued)

Patient Name:_____ Date: _____

Please read: This questionnaire has been designed to give the provider information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only one answer that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes your problem.

Section 1: Pain Intensity

☐ I can tolerate the pain I have without having to use painkiller.
☐ The pain is bad, but I manage without taking 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 the pain and I do not use them.

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.
☐ It is painful to look after myself but I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need some help everyday in most aspects of selfcare.
☐ I do not get dressed, wash with difficulty, stay in bed.

Section 3: Lifting

☐ I can lift heavy weights without causing 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

☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking ¼ mile.
☐ I can only walk using a stick/cane or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.
☐ Pain does not prevent me from walking any distance.

Section 5: Sitting

☐ I can sit still in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than an hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all

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 more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes
☐ Pain prevents me from standing at all.

Section 7: Sleeping

☐ Pain does not prevent me from sleeping at all
☐ 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

☐ 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 gives 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

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I can manage journeys over 2 hours
☐ Pain restricts me to journeys of less than 1 hour.
☐ Pain restricts me to short, necessary journeys of less than 30 minutes.
☐ Pain prevents me from traveling except to the doctors or hospital.

This spine follow-up form has been reviewed by:_____ MD/NP/PA Date:_____

Patient Name:_____

This questionnaire asks for your views about your general health. This information will help keep tract of how you are feeling and how well you are able to do your usual activities. For each of the following questions, please mark with an "X" in the one box that best describes your answer. Please do not skip any questions.

1. In general, would you say your health is:

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?

   ☐ Much better now than ☐ Somewhat better than 1 year ago
   ☐ About the same as 1 year ago ☐ Somewhat worse now than 1 year ago
   ☐ Much worse now than 1 year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes Limited a lot	Yes Limited a little	Yes Not limited at all
a. Vigorous activities, such as running, lifting, heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than one mile	☐	☐	☐
h. Walking several blocks	☐	☐	☐
i. Walking one block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. Cut down the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kid of work or other activities	☐	☐
d. Had difficulty performing the work or other activities (e.g. it took extra effort)	☐	☐

5. During the past 4 weeks have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems such as feeling depressed or anxious?)

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Didn't do work or other activities as carefully as usual	☐	☐

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

7. How much bodily pain have you had during the past 4 weeks

☐None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outsider the home and housework?)

☐Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling
How much of the time during the past 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b. Have you been nervous?	☐	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps?	☐	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐	☐
i. Do you feel tired?	☐	☐	☐	☐	☐	☐

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐All of the time ☐ Most of the time ☐ Some of the time ☐A little of the time ☐ None of the time

11. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than others	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know	☐	☐	☐	☐	☐
c. I expect my health to get worse	☐	☐	☐	☐	☐
d. My health is excellent	☐	☐	☐	☐	☐

Patient Signature:_____ Date:_____