



Lumbar Spine

New Patient Forms



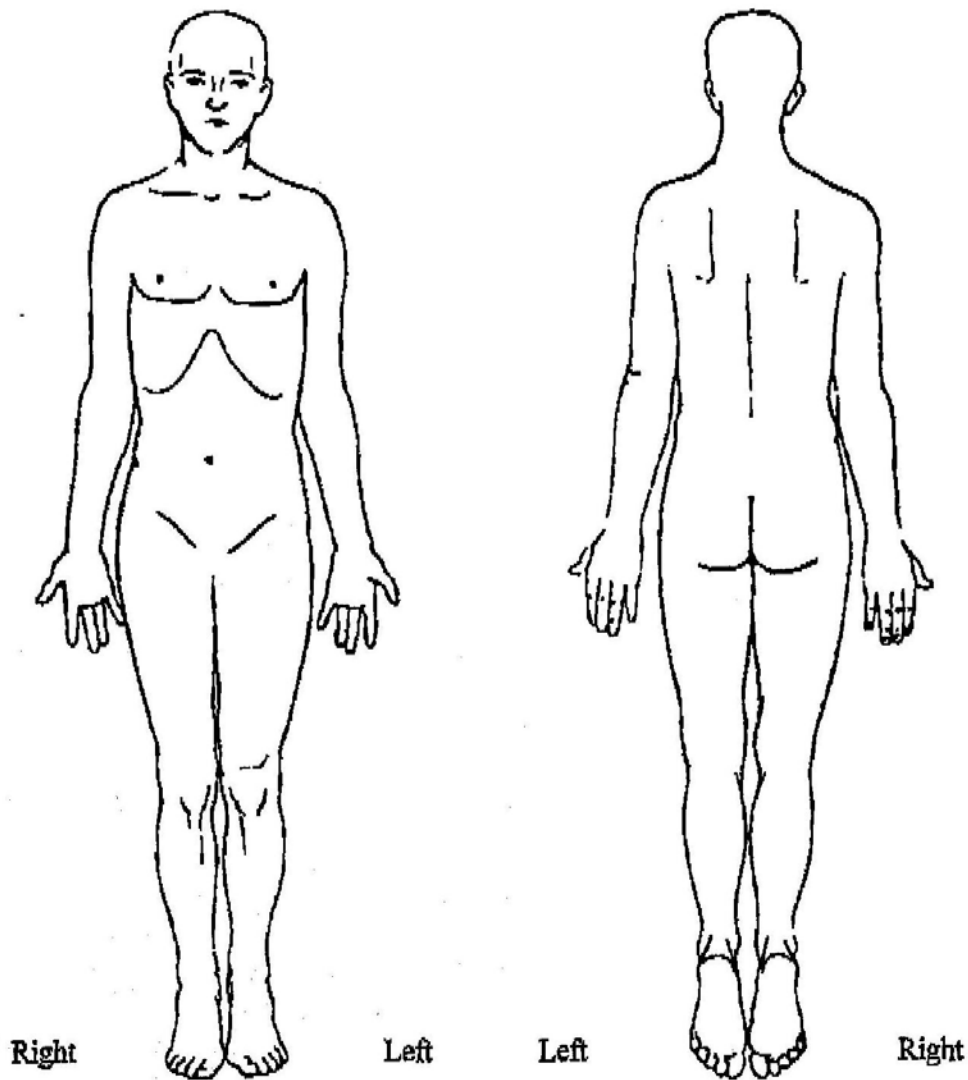
Your cooperation in answering all these questions is greatly appreciated.
It will help in your evaluation

Name: _____ Date: _____

Pain Drawing

This pain drawing will help us understand the pain you have been experiencing. Using the diagrams below, use the symbols listed below to indicate what type of pain you are having and where it is located:

---	Numbness
□□□	Pins and needles
○○○	Burning pain
△△△	Stabbing pain
×××	Aching pain



Name: _____ Date: _____

Date of Birth: _____ Gender: M F

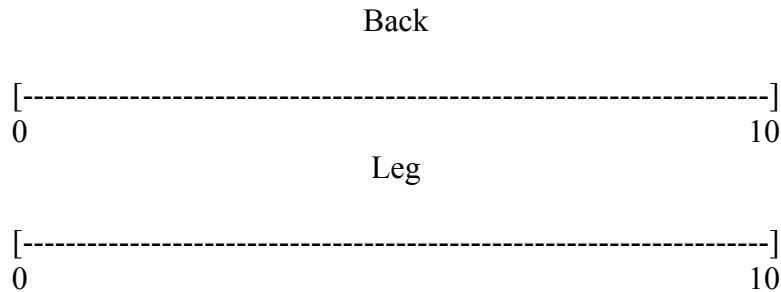
What is your Height: _____ What is your Weight: _____

Who referred you here: _____

MAJOR Complaint: (if both back and leg please give a PERCENTAGE in each)

Pain in: Back _____ Leg _____ Left _____ Right _____

Please indicate the severity of the pain as it is *most* of the time by marking the line with a SINGLE vertical line “|” (0=no pain, 10=worst pain)



Duration of current symptoms: _____ Weeks _____ Months _____ Years

Date of initial onset (if known): _____

Is there numbness and/or tingling associated with the pain: Yes No

Is there weakness in the affected leg or foot: Yes No

Have you noticed bowel or bladder problems (e.g. incontinence): Yes No

What have you tried for your symptoms thus far:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Traction | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> Injections | <input type="checkbox"/> Medications | <input type="checkbox"/> Other: _____ |

Indicate which activities WORSEN your symptoms:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Bending backward |

Indicate which activities IMPROVE your symptoms:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Bending backward |

Name: _____ Date: _____

Is your pain worse:

- In the morning
- Mid-day
- In the evening
- Other: _____

Is your pain better:

- In the morning
- Mid-day
- In the evening
- Other: _____

Which studies of your neck or back, if any, have you had in the last 2 years:

- Regular X-rays
- Bending X-rays
- MRI
- CT Scan
- Myelogram
- EMG
- Discogram
- CT Myelogram

Indicate any Medical History you have:

- High blood pressure
- Heart
- Lung
- Diabetes
- Thyroid
- Kidneys
- Liver
- Stomach
- Other (Please list): _____

Have you ever had neck or back surgery before: Yes No

Please list ALL prior surgeries (Spine AND Non-Spine) with dates (Month/Year):

List (or include a list) of all current Medications:

Are you Allergic to any medications: Yes No

If yes, please list Medication(s) and Reaction(s): _____

Name: _____ Date: _____

Do you smoke or use Tobacco products: Yes No

If yes, for how long: _____

Packs smoked per day: <1/2 1/2 1 2 3 4

Do you drink Alcohol: Yes No

If yes, drinks per day: <1 1 2 3 4 5 >5

Do you use any other Drugs: Yes No If yes, which drugs: _____

Are you on Disability: Yes No If yes, Date started: _____

Is there a lawsuit associate with this injury: Yes No

Is this a workman’s compensation claim: Yes No

If yes, When was the date of injury: _____

BRIEFLY describe the mechanism of injury: _____

Are you currently: Employed Unemployed Student Retired

If employed, what is your occupation: _____

Are you presently working: Yes No

If no, what is the last date worked: _____

Are you: Married/Partnered Single Divorced/Separated Widowed

Number of Children, if any: _____

List any family member, with history of heart, lung, liver or kidney disease; arthritis, gout, glaucoma, or cancer; neck or back problems:

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Relationship: _____ Disease: _____

Name: _____ Date: _____

EXTENDED REVIEW OF SYSTEMS: Do you presently have any problems or symptoms in the following areas? If “Yes”, please explain briefly:

	Yes	No	Explanation:	Provider Comments:
1. General				
Good health	<input type="checkbox"/>	<input type="checkbox"/>		
Unexplained hair loss (alopecia)	<input type="checkbox"/>	<input type="checkbox"/>		
Recent unintentional weight change	<input type="checkbox"/>	<input type="checkbox"/>		
Fever, chills, sweats	<input type="checkbox"/>	<input type="checkbox"/>		
2. Eyes				
Wear glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>		
Vision problems (blurred, double, or loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>		
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ears/Nose/Mouth/Throat				
Change in hearing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>		
Recent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>		
Swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		
Sore throat or pain when swallowing	<input type="checkbox"/>	<input type="checkbox"/>		
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>		
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>		
Voice changes	<input type="checkbox"/>	<input type="checkbox"/>		
4. Cardiovascular				
Heart trouble or heart attack	<input type="checkbox"/>	<input type="checkbox"/>		
Chest pain/angina (sharp, crushing, or heaviness)	<input type="checkbox"/>	<input type="checkbox"/>		
Heart racing/palpitations/arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>		
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>		
Swelling of legs (edema)	<input type="checkbox"/>	<input type="checkbox"/>		
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>		
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>		
5. Respiratory				
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		
Cough	<input type="checkbox"/>	<input type="checkbox"/>		
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>		
Recent pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		
6. Gastrointestinal				
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>		
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>		
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>		
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
7. Endocrine				
Excessive thirst or urination	<input type="checkbox"/>	<input type="checkbox"/>		
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		
8. Hematologic/Lymphatic				
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent bleeding	<input type="checkbox"/>	<input type="checkbox"/>		
Swollen glands/lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>		
9. Skin and breasts				
Rashes or sores	<input type="checkbox"/>	<input type="checkbox"/>		
Birth marks	<input type="checkbox"/>	<input type="checkbox"/>		

Name: _____ Date: _____

Changing moles	<input type="checkbox"/>	<input type="checkbox"/>		
Skin cancer or melanoma	<input type="checkbox"/>	<input type="checkbox"/>		
Non-healing wounds	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in skin	<input type="checkbox"/>	<input type="checkbox"/>		
Breast pain or lump	<input type="checkbox"/>	<input type="checkbox"/>		
10. Allergic/Immunologic				
Allergic reaction to drugs	<input type="checkbox"/>	<input type="checkbox"/>		
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>		
Hives/skin rashes	<input type="checkbox"/>	<input type="checkbox"/>		
Allergic reaction to foods	<input type="checkbox"/>	<input type="checkbox"/>		
Low resistance to infection	<input type="checkbox"/>	<input type="checkbox"/>		
Recent cold or flu	<input type="checkbox"/>	<input type="checkbox"/>		
Tetanus booster within last 10 years	<input type="checkbox"/>	<input type="checkbox"/>		
Other immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>		
11. Genitourinary				
Painful or burning urination	<input type="checkbox"/>	<input type="checkbox"/>		
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent urination (day and/or night)	<input type="checkbox"/>	<input type="checkbox"/>		
Change in force of stream when urinating	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder infection/other infections	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in sexual function or interest	<input type="checkbox"/>	<input type="checkbox"/>		
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>		
<i>Women:</i>				
Irregular periods (menstruation)	<input type="checkbox"/>	<input type="checkbox"/>		
Pain, problems, or changes with periods (menstruation)	<input type="checkbox"/>	<input type="checkbox"/>		
Uterine tumors	<input type="checkbox"/>	<input type="checkbox"/>		
<i>Men:</i>				
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>		
Scrotal Masses	<input type="checkbox"/>	<input type="checkbox"/>		
12. Musculoskeletal				
Limited motion of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Joint stiffness or pain	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>		
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>		
Back pain	<input type="checkbox"/>	<input type="checkbox"/>		
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>		
13. Neurological				
Numbness or tingling in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Problems with memory, concentration or speech	<input type="checkbox"/>	<input type="checkbox"/>		
14. Psychiatric				
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>		
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>		
Changes in sleep	<input type="checkbox"/>	<input type="checkbox"/>		
Seeing or hearing things (hallucinations)	<input type="checkbox"/>	<input type="checkbox"/>		
Thoughts of hurting or killing yourself or others	<input type="checkbox"/>	<input type="checkbox"/>		
15. Other (Please write in):				

Name: _____ Date: _____

OSWESTRY DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer each section by checking the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CHECK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 - Pain Intensity</p> <p><input type="checkbox"/> I have no pain at the moment</p> <p><input type="checkbox"/> The pain is very mild at the moment</p> <p><input type="checkbox"/> The pain is moderate at the moment</p> <p><input type="checkbox"/> The pain is fairly severe at the moment</p> <p><input type="checkbox"/> The pain is very severe at the moment</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment</p>	<p>SECTION 6 - Standing</p> <p><input type="checkbox"/> I can stand as long as I want without extra pain</p> <p><input type="checkbox"/> I can stand as long as I want but it gives me extra pain</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 1 hour</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from standing for more than 10 minutes</p> <p><input type="checkbox"/> Pain prevents me from standing at all</p>
<p>SECTION 2 - Personal Care (Washing, Dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain</p> <p><input type="checkbox"/> I can look after myself normally, but it causes extra pain</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful</p> <p><input type="checkbox"/> I need some help, but manage most of my personal care</p> <p><input type="checkbox"/> I need help every day in most aspects of self care</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed</p>	<p>SECTION 7 - Sleeping</p> <p><input type="checkbox"/> My sleep is never disturbed by pain</p> <p><input type="checkbox"/> My sleep is occasionally disturbed by pain</p> <p><input type="checkbox"/> Because of pain I have less than 6 hours sleep</p> <p><input type="checkbox"/> Because of pain I have less than 4 hours sleep</p> <p><input type="checkbox"/> Because of pain I have less than 2 hours sleep</p> <p><input type="checkbox"/> Pain prevents me from sleeping at all</p>
<p>SECTION 3 - Lifting</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain</p> <p><input type="checkbox"/> I can lift heavy weights, but it gives extra pain</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned</p> <p><input type="checkbox"/> I can lift very light weights</p> <p><input type="checkbox"/> I cannot lift or carry anything at all</p>	<p>SECTION 8 - Sex Life (if applicable)</p> <p><input type="checkbox"/> My sex life is normal and causes no extra pain</p> <p><input type="checkbox"/> My sex life is normal but causes some extra pain</p> <p><input type="checkbox"/> My sex life is nearly normal but is very painful</p> <p><input type="checkbox"/> My sex life is severely restricted by pain</p> <p><input type="checkbox"/> My sex life is nearly absent because of pain</p> <p><input type="checkbox"/> Pain prevents any sex life at all</p>
<p>SECTION 4 - Walking</p> <p><input type="checkbox"/> Pain does not prevent me walking any distance</p> <p><input type="checkbox"/> Pain prevents me from walking more than 1 mile</p> <p><input type="checkbox"/> Pain prevents me from walking more than ½ mile</p> <p><input type="checkbox"/> Pain prevents me from walking more than 100 yards</p> <p><input type="checkbox"/> I can only walk using a stick or crutches</p> <p><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet</p>	<p>SECTION 9 - Social Life</p> <p><input type="checkbox"/> My social life is normal and gives me no extra pain</p> <p><input type="checkbox"/> My social life is normal but increases the degree of pain</p> <p><input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport</p> <p><input type="checkbox"/> Pain has restricted my social life and I do not go out as often</p> <p><input type="checkbox"/> Pain has restricted my social life to my home</p> <p><input type="checkbox"/> I have no social life because of pain</p>
<p>SECTION 5 - Sitting</p> <p><input type="checkbox"/> I can sit in any chair as long as I like</p> <p><input type="checkbox"/> I can only sit in my favourite chair as long as I like</p> <p><input type="checkbox"/> Pain prevents me sitting more than one hour</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from sitting more than 10 minutes</p> <p><input type="checkbox"/> Pain prevents me from sitting at all</p>	<p>SECTION 10 - Travelling</p> <p><input type="checkbox"/> I can travel anywhere without pain</p> <p><input type="checkbox"/> I can travel anywhere but it gives me extra pain</p> <p><input type="checkbox"/> Pain is bad but I manage journeys over two hours</p> <p><input type="checkbox"/> Pain restricts me to journeys of less than one hour</p> <p><input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes</p> <p><input type="checkbox"/> Pain prevents me from travelling except to receive treatment</p>

Name: _____ Date: _____

MSPQ

Please describe how you have felt during the PAST WEEK by making an X in the appropriate box. Please answer ALL questions. Do not think too long before answering.

	Not at all.	Slightly. A little.	A great deal.	Extremely. Could not have been worse.
Heart rate increase...				
Feeling hot all over				
Sweating all over				
Sweating in a particular part of body...				
Pulse in neck...				
Pounding in head...				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal...				
Nausea				
Butterflies in stomach...				
Pain or ache in stomach				
Stomach churning				
Desire to pass water...				
Mouth becoming dry				
Difficulty swallowing...				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles...				

Name: _____ Date: _____

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Please indicate by making an X in the appropriate box) the answer that best describes how you have been feeling recently. Please answer ALL questions. Do not think too long before answering.

	Rarely or none of the time	Some of the time (1-2 days per week)	Good part of the time (3-4 days per week)	Most of the time (5-7 days per week)
I feel downhearted and sad				
Morning is when I feel the best...				
I have crying spells, or feel like it				
I have trouble sleeping at night				
I feel that nobody cares				
I eat as much as I used to...				
I still enjoy sex...				
I notice that I am losing weight				
I have troubles with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be...				
I tend to wake up too early				
I find it easy to do the things I used to...				
I am restless and can't keep still				
I feel hopeful about the future...				
I am more irritable than usual				
I find it easy to make decisions...				
I feel quite guilty				
I feel that I am useful and needed...				
My life is pretty full...				
I feel that others would be better off if I were dead				
I still enjoy the things I used to do...				