



steadman-hawkins

Practitioner's Initials: _____

Welcome to the Spine Clinic at Steadman-Hawkins. Please take a few minutes to complete the attached questionnaire. Depending on your problem, some questions may seem redundant or unrelated to your symptoms. Please try to answer all of the questions completely. Having the most complete information gives us the best chance to accurately diagnose and treat your problem. If there is insufficient space to answer any question, please use the back of the page.

Thank you,
Michael W. Madsen, M.D. – *Spinal Surgeon*

Name: _____ Age: _____

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

Family Physician: _____ Referring Physician: _____

Reason for seeing doctor: _____

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

How did your symptoms start? gradually suddenly

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

Please describe the evolution of your symptoms since their onset:

Please describe your symptoms as they currently affect you:

What questions would you like to have answered during your visit to Steadman-Hawkins?

Since the onset of your problem, are you: Getting better Getting worse Staying the same

Please rate your pain on a scale of 1 – 10 (0 = no pain, 10 = worst pain imaginable).

Present pain level: _____ Average pain level: _____, present _____% of the time.

Worst pain level: _____, present _____% of the time.

Lowest pain level: _____, present _____% of the time.

In percentages, how much pain is in your back/neck and how much is in your legs/arms?

_____ % in my back/neck. + _____ % in my legs/arms. = 100%

What is the character of your pain? Aching Throbbing
 Electrical Muscle cramp Dull Sharp

What makes your symptoms better? _____

What makes your symptoms worse? _____

What medicine(s) do you *currently* take for pain? _____

During the last month, how frequently have you been taking medicine for 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 part 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 mile About a mile A few miles No limitation

Please **check** and **list the approximate date** if you have had any diagnostic tests for your spine:
 X-Rays MRI EMG CT scan or myelogram
 Bone scan Discogram Other – *please specify:* _____

Have you had **injections** in or around your spine? Yes No
Date: _____ Type of injection: _____ Your response to the injection: _____

What **treatments** have you tried? Physical therapy Acupuncture
 Pain management program Chiropractic care Traction
Date: _____ Type of treatment: _____ Your response to the treatment: _____

Have you had **surgery** on your spine? Yes No
Date: _____ Surgeon: _____ Surgical procedure: _____

Have you noticed any recent changes in your **bowel** or **bladder** function? Yes No
Is your pain **worse at night**? Yes No Are you having **fevers**? Yes No
Are you having problems with your **balance**? Yes No
Are you having problems with **coordination**, such as difficulties buttoning clothes or a change in your handwriting? Yes No

Do you have any **medical problems**? (*Please individually mark each item.*)
History of blood clots Yes No HIV Yes No
Cancer (type: _____) Yes No Hypertension Yes No
Chemical dependency or alcoholism Yes No Hypercholesterolemia Yes No
Diabetes Yes No Hypothyroidism Yes No
Heart disease Yes No Kidney Failure Yes No
Fibromyalgia Yes No Osteoporosis Yes No
Hepatitis Yes No Rheumatoid arthritis Yes No
Other – *please specify:* _____

Please **check** and **list the approximate date** if you have had any of the following surgeries:

- Heart surgery Lung surgery Appendectomy Hernia repair

Other – please describe: _____

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

- Fever, weight loss
Eye, ear, nose or throat
Heart problems
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 and the reaction the medication causes:

Medication Reaction

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

Medication Dosage (amount and frequency) Reason

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

- 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): _____. I smoked for a total of _____ years.

How much do (or did) you smoke most days? Half a pack One pack Two packs or more

How much alcohol do you drink in an average week? None 4 or more drinks daily
 2 or 3 drinks daily 1 drink daily A few drinks a week One drink a week or less

Have you ever taken illicit drugs (e.g. cocaine, heroin, methamphetamine)? Yes No

Have you retained an attorney 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

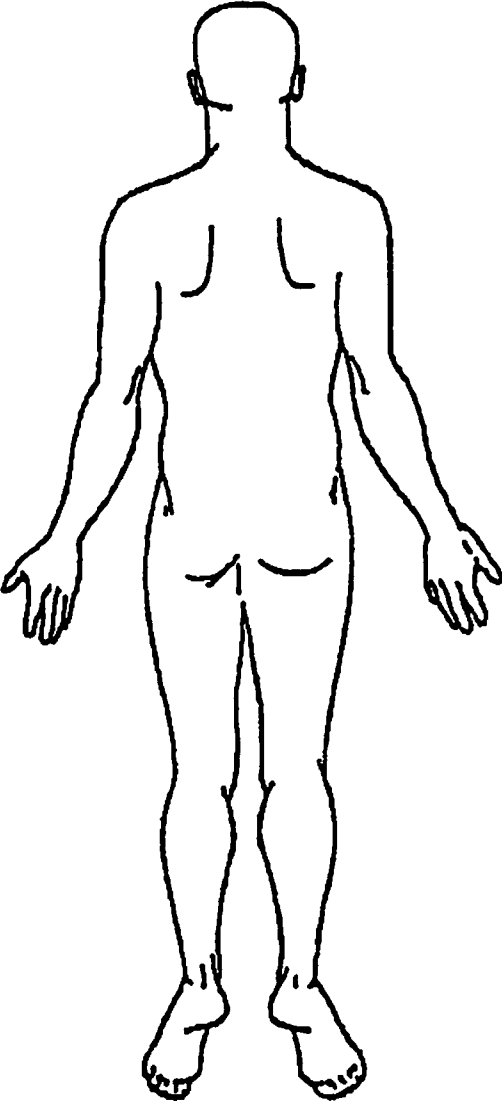
Answer the following based on your **current employment** or **last employment if not working**:
Occupation? _____ Average number of hours a week you work? _____

Please describe the physical requirements of your work:

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

Pain XXXX
Numbness OOOO
Tingling IIII

BACK



FRONT

