MEMORIAL ORTHOPAEDIC SURGICAL GROUP
A MEDICAL CORPORATION
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SPINE CENTER QUESTIONAIRE

Patient Name: _____

Date of Visit: _____

Please read and complete the attached questionaire. As you answer each section, please be as specific as possible about your condition. Feel free to use the back of the pages if you need more room to tell us what you want us to know. Your answers, in addition to your examination, will enable us to reach an accurate diagnosis and will assist us in designing a program to meet your specific needs.

Please check each section to see if all the questions have been answered.

If this questionaire was mailed to you, it must be returned at the time of your first visit. This will save you the time of completing another one when you arrive at the Spine Center.

Remember, we share a common goal — your good health and well-being.

NAME: _____ DATE: _____

What is being examined today? _____ Which side? (RIGHT/LEFT) _____

Were X-RAYS/MRI taken? ☐ YES ☐ NO Did you bring them in? ☐ YES ☐ NO

1. DATE of accident, **OR** HOW LONG have you had ILLNESS/PROBLEM/SYMPTONS: _____

2. BRIEFLY DESCRIBE illness/injury/symptoms requiring treatment below (@***HOW**) and include:

   a. **WHERE** it occurred: ☐ HOME ☐ SCHOOL ☐ OTHER (PLEASE SPECIFY): _____

   ☐ WORK (If so, did it occur while working for wages? ☐ YES ☐ NO ☐ UNSURE)

   ☐ MOTOR VEHICLE ACCIDENT (If so, do you have auto insurance? ☐ YES ☐ NO)

   *b. **HOW** illness/problem/symptoms/accident occurred: _____

   _____

   _____

   _____

   _____

   c. Is there a third party involved? ☐ YES ☐ NO

3. Have you seen a physician for this problem? ☐ YES ☐ NO

   a. DOCTOR: _____ ADDRESS: _____

   b. TREATMENT (special tests, injections, medications, etc.):

   _____

   _____

4. Have you had a previous problem in this area? ☐ YES ☐ NO If so, please describe:

   _____

   _____

   _____

   _____

5. Have you lost time from work because of this current injury/problem? ☐ YES ☐ NO

   If yes, DATE LAST WORKED: _____

6. Briefly describe your job activities: (lifting, pushing, pulling, driving, etc.)

   _____

   _____

7. Please describe present complaints:

   _____

   _____

   _____

   _____

   _____

8. Do you feel your symptoms are: ☐ IMPROVED ☐ MORE SEVERE ☐ REMAINED THE SAME

NAME: _____ DATE: _____

GENERAL HEALTH: *(circle one)* GOOD FAIR POOR

Yes ___ No ___ Have you ever been seriously ill?

Yes ___ No ___ Have you ever been hospitalized?

Yes ___ No ___ Have you had surgery? When _____

What kind? _____

YES ___ NO ___ ARE YOU PREGNANT?

HAVE YOU EVER HAD:

Yes ___ No ___ Cancer

Yes ___ No ___ Heart Trouble

Yes ___ No ___ Difficulty with breathing

Yes ___ No ___ Lung disease (for instance: pneumonia, asthma or emphysema)

Yes ___ No ___ Jaundice, hepatitis

Yes ___ No ___ Diabetes

Yes ___ No ___ Fainting spells

Yes ___ No ___ Allergies to medications (if yes, what medications and what type of reaction; rash, swelling, etc.) _____

Yes ___ No ___ Rheumatic Feaver

Yes ___ No ___ High Blood Pressure

Yes ___ No ___ Anemia or bleeding problems

Yes ___ No ___ Other serious health problems: What _____

_____

DO YOU:

Yes ___ No ___ Take medication regularly (including birth control pills). What kind _____

_____

_____

Yes ___ No ___ Smoke _____ pkg/day

Yes ___ No ___ Drink Alcohol (if so, do you have it daily, socially, occasionally, rarely) _____

HAVE YOU EVER HAD:

Yes ___ No ___ Broken bones (if so, which ones and when) _____

Yes ___ No ___ Head injuries When _____

Yes ___ No ___ Neck injuries When _____

Yes ___ No ___ Back injuries When _____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EVER HAD:

Yes ___ No ___ Cancer

Yes ___ No ___ Heart Disease

Yes ___ No ___ Lung Diseases, TB, etc.

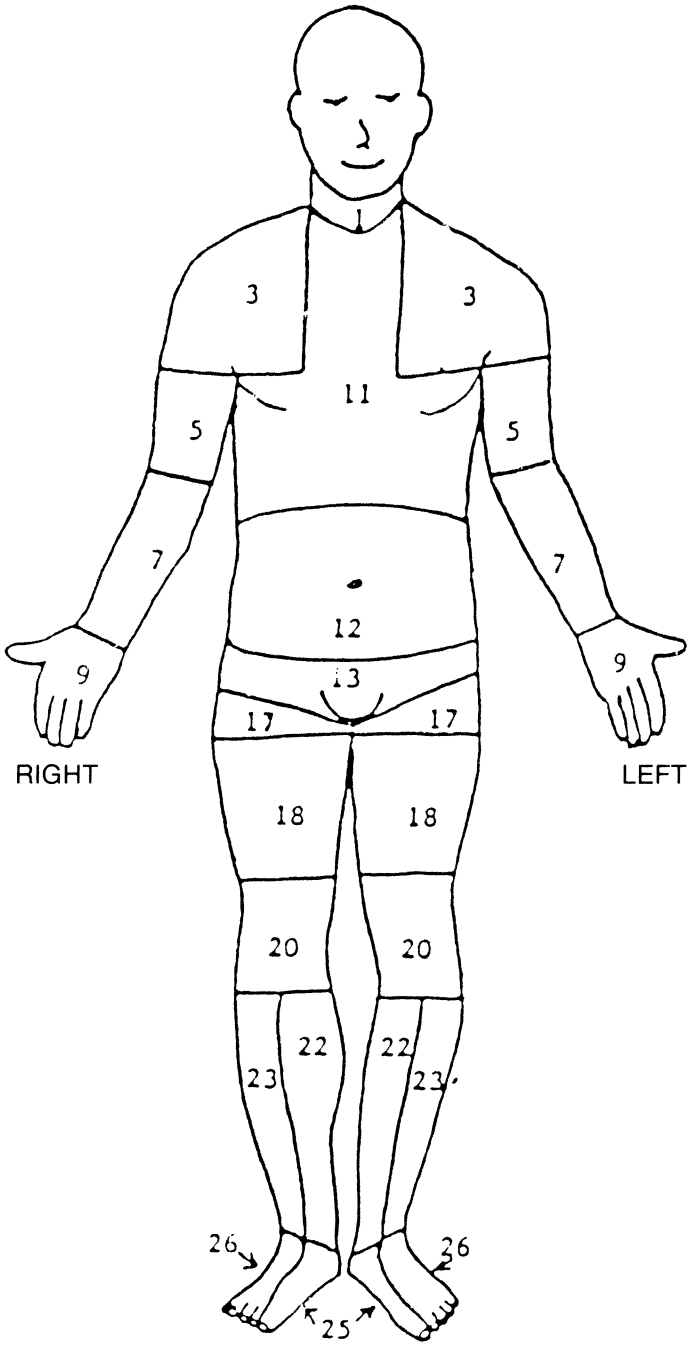
Yes ___ No ___ Diabetes

Ht: _____ **Wt.** _____ **Right/Left handed** _____

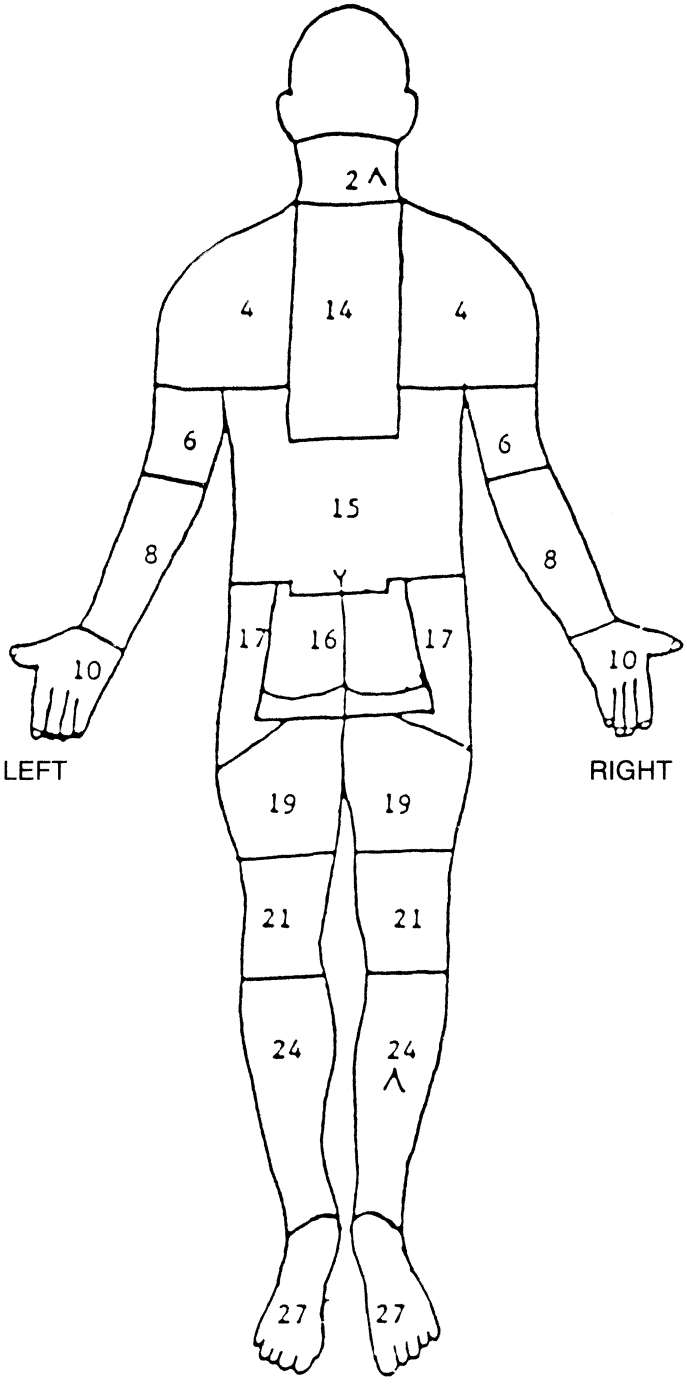
Use the body diagram below to indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

—	—	—	—	—	Numbness
o	o	o	o	o	Pins and Needles
x	x	x	x	x	Burning pain
/	/	/	/	/	Stabbing pain
/\	/\	/\	/\	/\	Aching pain

FRONT



BACK



Put a checkmark next to the activities which change the nature of your pain:

	Aggravates Pain	Relieves Pain
1) Sitting	_____	_____
2) Standing	_____	_____
3) Rising from sitting	_____	_____
4) Leaning forward (brushing teeth)	_____	_____
5) Walking	_____	_____
6) Lying on your side	_____	_____
7) Lying on your back	_____	_____
8) Lying on your stomach	_____	_____
9) Driving	_____	_____
10) Coughing/Sneezing	_____	_____
11) Bending forward	_____	_____

Now go back and put an asterisk (*) next to the most aggravating activity and the most relieving activity.

Please answer the following questions using the following chart:

1 = Unable to tolerate
2 = Several minutes only
3 = About 10 minutes only
4 = About 20 minutes only
5 = About 1/2 hour
6 = About 1 hour
7 = Several hours
8 = Indefinite period

1) How long can you sit? _____

2) How long can you stand? _____

3) How long can you walk? _____

McGILL PAIN QUESTIONNAIRE

Some of the words below describe your PRESENT pain. Circle ONLY those words that best describe it. Leave out any category that is not suitable. Mark only one word in each category.

A

1 — Flickering
2 — Quivering
3 — Pulsing
4 — Throbbing
5 — Beating
6 — Pounding

B

1 — Jumping
2 — Flashing
3 — Shooting

C

1 — Pricking
2 — Boring
3 — Drilling
4 — Stabbing
5 — Lancination

D

1 — Sharp
2 — Cutting
3 — Lacerating

E

1 — Pinching
2 — Pressing
3 — Gnawing
4 — Cramping
5 — Crushing

F

1 — Tugging
2 — Pulling
3 — Wrenching

G

1 — Hot
2 — Burning
3 — Scalding
4 — Searing

H

1 — Tingling
2 — Itching
3 — Smarting
4 — Stinging

I

1 — Dull
2 — Sore
3 — Hurting
4 — Aching
5 — Heavy

J

1 — Tender
2 — Taut
3 — Rasping
4 — Splitting

K

1 — Tiring
2 — Exhausting

L

1 — Sickening
2 — Suffocating

M

1 — Fearful
2 — Frightful
3 — Terrifying

N

1 — Punishing
2 — Grueling
3 — Cruel
4 — Vicious
5 — Killing

O

1 — Wretched
2 — Blinding

P

1 — Annoying
2 — Troublesome
3 — Miserable
4 — Intense
5 — Unbearable

Q

1 — Spreading
2 — Radiating
3 — Penetrating
4 — Piercing

R

1 — Tight
2 — Numb
3 — Drawing
4 — Squeezing
5 — Tearing

S

1 — Cool
2 — Cold
3 — Freezing

T

1 — Nagging
2 — Nauseating
3 — Agonizing
4 — Dreadful
5 — Torturing

OSWESTRY FUNCTION TEST

Using the following chart, please answer the following questions, placing the number of the most applicable answer on the blank lines:

1. How long have you had back pain? _____
2. How long have you had leg pain? _____
3. How long have you had neck pain? _____

1 = Unknown
2 = About 1 day
3 = About 3 days
4 = About 1 week
5 = About 1 month
6 = About 3 months
7 = About 6 months
8 = About 6 months to 1 year
9 = About 1 to 2 years
10 = About 2 to 3 years
11 = About 3 to 5 years
12 = More than 5 years

Please circle the one answer in each section that best applies to your condition.

PAIN INTENSITY
1 — I can tolerate my pain without having to use pain killers.
2 — My pain is bad but I manage without taking pain killers.
3 — Pain killers give me complete relief from my pain.
4 — Pain killers give me moderate relief from my pain.
5 — Pain killers give me very little relief from my pain.
6 — Pain killers have no effect on my pain and I do not use them.

PERSONAL CARE *(Washing, Dressing, Etc.)*
1 — I can look after myself normally without causing extra pain.
2 — I can look after myself normally but it causes extra pain.
3 — It is painful to look after myself and I am slow and careful.
4 — I need some help, but I manage most of my personal care.
5 — I need help every day in most aspects of self care.
6 — I do not get dressed, wash with difficulty, and stay in bed.

LIFTING
1 — I can lift heavy objects without extra pain.
2 — I can lift heavy objects but it gives extra pain.
3 — Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned.
4 — Pain prevents me from lifting heavy objects, but I can manage light to medium objects if they are conveniently positioned.
5 — I can only lift very light objects.
6 — I cannot lift or carry anything at all.

WALKING
1 — Pain does not prevent me from walking any distance.
2 — Pain prevents me from walking more that 1 mile.
3 — Pain prevents me from walking more than 1/2 mile.
4 — Pain prevents me from walking more than 1/4 mile.
5 — I can only walk using a cane or crutches.
6 — I am in bed most of the time and have to crawl to the toilet.

SITTING
1 — I can sit in any chair as long as I like.
2 — I can only sit in my favorite chair as long as I like.
3 — Pain prevents me from sitting more than 1 hour.
4 — Pain prevents me from sitting more than 1/2 hour.
5 — Pain prevents me from sitting more than 10 minutes.
6 — Pain prevents me from sitting at all.

STANDING
1 — I can stand as long as I want without extra pain.
2 — I can stand as long as I want but it gives me extra pain.
3 — Pain prevents me from standing more than 1 hour.
4 — Pain prevents me from standing more than 1/2 hour.
5 — Pain prevents me from standing more than 10 minutes.
6 — Pain prevents me from standing at all.

SLEEPING
1 — Pain does not prevent me from sleeping well.
2 — I can sleep well only by taking medication for sleep.
3 — Even when I take medication, I have less than 6 hours sleep.
4 — Even when I take medication, I have less than 4 hours sleep.
5 — Even when I take medication, I have less than 2 hours sleep.
6 — Pain prevents me from sleeping at all.

SEX LIFE
1 — My sex life is normal and causes me no extra pain.
2 — My sex life is normal but causes me some extra pain.
3 — My sex life is nearly normal but is very painful.
4 — My sex life is severely restricted by pain.
5 — My sex life is nearly absent because of pain.
6 — Pain prevents any sex life at all.

SOCIAL LIFE
1 — My social life is normal and causes me no extra pain.
2 — My social life is normal but increases the degree of pain.
3 — Pain has no significant effect on my social life apart from limiting my more energetic interests like dancing, etc.
4 — Pain has restricted my social life and I do not go out as often.
5 — Pain has restricted my social life to my home.
6 — I have no social life because of pain.

TRAVELING
1 — I can travel anywhere without pain.
2 — I can travel anywhere but it gives me extra pain.
3 — Pain is bad but I manage journeys over 2 hours.
4 — Pain restricts me to journeys of less than 1 hour.
5 — Pain restricts me to short necessary journeys under 1/2 hour.
6 — Pain prevents me from traveling except to the doctor or hospital.

CURRENT PAIN PROFILE

How would you compare your pain ratio? *(circle one)*

For Back & Leg Pain Only:
1 — 100% back pain and 0% leg pain
2 — 75% back pain and 25% leg pain
3 — 50% back pain and 50% leg pain
4 — 25% back pain and 75% leg pain
5 — 0% back pain and 100% leg pain

For Neck & Arm Pain Only:
1 — 100% neck pain and 0% arm pain
2 — 75% neck pain and 25% arm pain
3 — 50% neck pain and 50% arm pain
4 — 25% neck pain and 75% arm pain
5 — 0% neck pain and 100% arm pain

Any areas of weakness:
Indicate location using the following chart: 1 = Right
2 = Left
3 = Right & Left
4 = Midline

1 — Ankle/foot _____
2 — Knee _____
3 — Hip _____
4 — Hand _____
5 — Wrist _____
6 — Elbow _____
7 — Shoulder _____
8 — Low back _____
9 — Mid back _____
10 — Upper back _____
11 — Neck _____

Please rate your pain over recent weeks using the following scale:
1 = No pain
2 = Mild pain
3 = Moderate requiring mild pain medications such as Tylenol or aspirin
4 = Severe causing you to markedly modify your activities and/or take strong medications such as codeine
5 = Intense so you can barely function
6 = Excruciating so that it is unbearable

1 — At its worst	1	2	3	4	5	6
2 — Most of the time (usual)	1	2	3	4	5	6
3 — At its best (least)	1	2	3	4	5	6
4 — In the morning:						
a) before getting out of bed	1	2	3	4	5	6
b) after getting out of bed	1	2	3	4	5	6
5 — Midday	1	2	3	4	5	6
6 — Evening	1	2	3	4	5	6
7 — Night time	1	2	3	4	5	6

ACTIVITY LEVEL IN LAST MONTH

Using the following chart, please estimate the amount of time you spend from 7:00 am to 11:00 pm each day performing the following activities:

1 = None
2 = Less than 1/2 hour
3 = 1/2 hour to 1 hour
4 = 1 to 2 hours
5 = 2 to 4 hours
6 = 4 to 6 hours
7 = 6 to 8 hours
8 = 8 to 10 hours

1 — Working _____

2 — Driving _____

3 — Housekeeping _____

4 — Sitting _____

5 — Walking _____

6 — In bed _____

7 — On couch or recliner _____

8 — Other major activity _____

Have you had spinal surgery in the past? N Y # _____

Have you had chemonucleolysis in the past? N Y

If you answered "yes" to either questions, please comple the following:

1 — What type of surgery was performed?

1 = Unknown

2 = Chymopapain injection

3 = Disc removal

4 = Fusion

5 = Disk removal with fusion

2 — How much time has passed since the procedure was performed?

	Most Recent Surgery	Chymopapain Injection
Unknown	= 1	1
About 1 day	= 2	2
About 3 days	= 3	3
About 1 week	= 4	4
About 1 month	= 5	5
About 3 months	= 6	6
About 6 months	= 7	7
About 6 months to a year	= 8	8
About 1 to 2 years	= 9	9
About 2 to 3 years	= 10	10
About 3 to 5 years	= 11	11
More than 5 years	= 12	12

3 — What was the date of your most recent surgery? _____ / _____ / _____

What was the date of your Chymopapain injection? _____ / _____ / _____

4 — Did you improve from your surgical procedure(s)?

	Most Recent Surgery	Chymopapain Injection
Yes	= 1	1
No	= 2	2

5 — If you answered "yes", please indicate how long the improvement lasted:

	Most Recent Surgery	Chymopapain Injection
Unknown	= 1	1
About 1 day	= 2	2
About 3 days	= 3	3
About 1 week	= 4	4
About 1 month	= 5	5
About 3 months	= 6	6
About 6 months	= 7	7
About 6 months to a year	= 8	8
About 1 to 2 years	= 9	9
About 2 to 3 years	= 10	10
About 3 to 5 years	= 11	11
More than 5 years	= 12	12

6 — Post surgery work status:

	Most Recent Surgery	Chymopapain Injection
Returned to work at my same job	= 1	1
Never returned to work	= 2	2
Returned to work on a part time basis	= 3	3
Returned to work at a less strenous job	= 4	4

Are you: 1 = Unemployed 2 = Employed 3 = Student 4 = Retired

If you answered "1" or "2", please answer the following questions:

1 — How long you have been off work this year:

1 = Unknown
2 = About 1 day
3 = About 3 days
4 = About 1 week
5 = About 1 month
6 = About 3 months
7 = About 6 months
8 = About 6 months to a year

2 — Are you presently working? Y N

If you answered "no", please complete the following:

1) What was the date last worked: _____ / _____ / _____

2) Is your job still available? Y N

3 — Was your reason for leaving work:

1 = Due to a back problem
2 = Not due to a back problem