The Spine and Sports Center

RETURN PATIENT QUESTIONNAIRE

Name:_____Today's Date: _____

Date of Birth:_____ Age:_____ Sex: _____

QUESTIONS ABOUT MY *CURRENT* PROBLEM

1. When were you last seen?
2. What are you being seen for?

3. Describe your current pain

4. Generally speaking, are your symptoms getting better, worse or the same**?** _____
   A. If **Better**, what **PERCENTAGE** improved? _____
   B. What Activities/Actions/Movements are you able to do better now (Improvement in Function)?

   _____

   _____

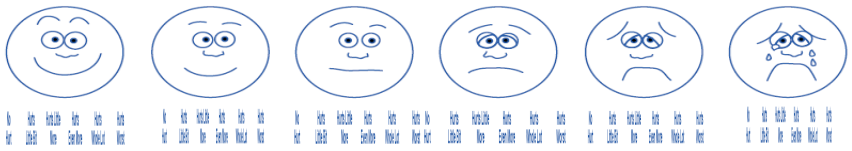
   C. Improvement in Motion?

   _____

   D. If improved, has there been a decrease in medication intake?

   _____

5. Circle the number between 0 and 10 to indicate your level of pain in this last week:



When it felt the worst this week	0	1	2	3	4	5	6	7	8	9	10
When it felt the best this week	0	1	2	3	4	5	6	7	8	9	10
Average for the week	0	1	2	3	4	5	6	7	8	9	10

TREATMENT HISTORY

Write all treatments you have received for this problem since your last visit:

□ Medication Changes:

-
-
-
-

□ Physical Therapy and/or Occupational Therapy. Where and Dates?

What did they teach you to do?

-
-
-
-

□ Injections or Nerve Blocks.

Where and dates? _____

What injections were done? _____

Surgery? If yes, what? _____

□ OTHER THINGS TRIED:

-
-
-
-
-

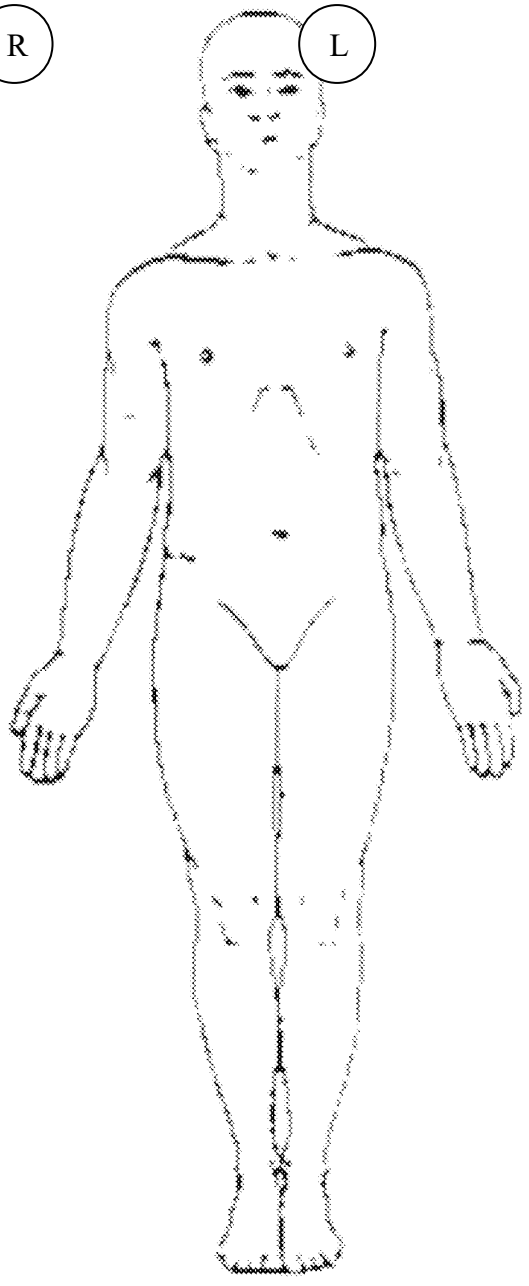
FUNCTIONAL STATUS:

□ yes □ no Do you have trouble getting to sleep because of pain

□ yes □ no Do you exercise? If yes how often _____

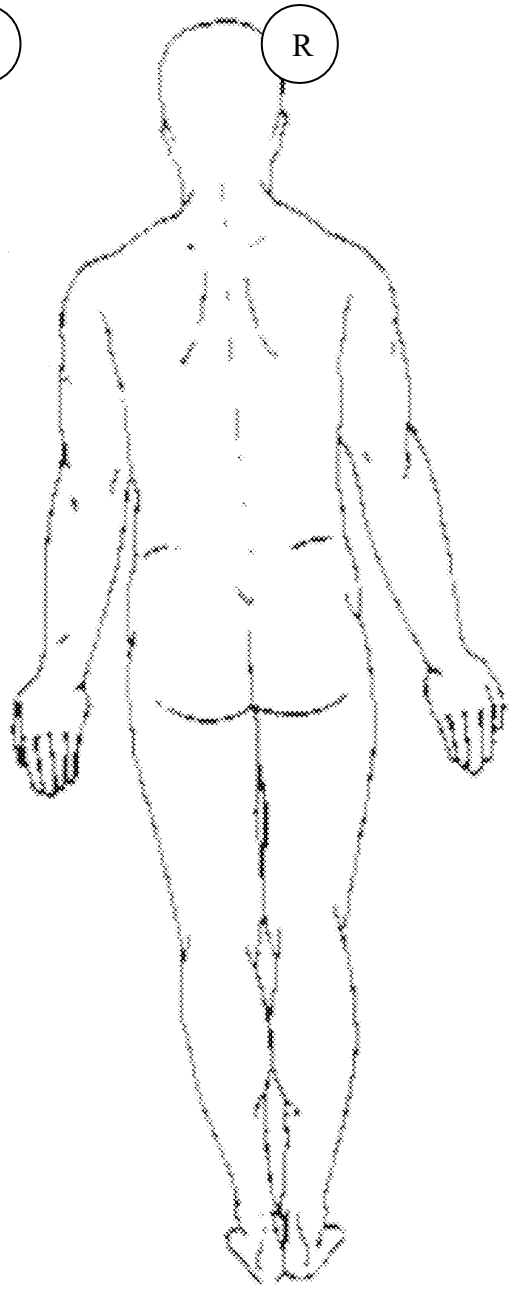
Mark the areas on the body where you feel your normal pain/numbness/tingling

R L



FRONT

L R



BACK

MEDICATIONS I AM ***CURRENTLY TAKING*** FOR ANY REASON (including non-prescription drugs)

Drug Name	Dose	How Often	For Pain Meds Only - - Does it help?
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

LIST ALL KNOWN ALLERGIES:

MEDICAL HEALTH HISTORY

PLEASE LIST ANY CHANGES IN MEDICAL HEALTH HISTORY OR ANY RECENT HOSPITALIZATIONS OR VISITS TO DOCTORS

THINGS THAT I AM ***CURRENTLY EXPERIENCING***

CHECK ALL THAT APPLY:

□ Fever or chills	□ Bowel incontinence	□ Urinary incontinence	□ Frequent Constipation
□ Hot or cold spells	□ Change of Vision	□ Swollen ankles	□ Hemorrhoids
□ Recent wt. change	□ Loss of hearing	□ Calf cramps w/walking	□ Frequent urination
□ Nervous exhaustion	□ Ear pain	□ Poor appetite	□ Burning on urination
□ Hoarseness	□ Tooth ache	□ Difficulty urinating	□ Nosebleeds
□ Gum trouble	□ Get up during night	□ Difficulty swallowing	□ Nausea or vomiting
□ Morning cough	□ Stomach pain	□ Frequent headaches	□ Shortness of breath
□ Ulcers	□ Blackouts	□ Reading glasses	□ Frequent belching
□ Seizures	□ Heart or chest pain	□ Frequent diarrhea	□ Frequent rash

Women ONLY

□ Irregular periods	□ Vaginal discharge	□ Frequent Spotting