

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_ ft. \_\_\_ in. WEIGHT: \_\_\_\_\_ lbs.

Referring doctor's name & address: \_\_\_\_\_

Internist or family doctor's name & address: \_\_\_\_\_  Same as above

### A. Chief Complaint

1. What is your MAIN reason for seeing the doctor? (Check all that apply)

\_\_\_ Neck pain                      Arm, shoulder, or hand: \_\_\_ Pain        \_\_\_ Numbness \_\_\_ Weakness

\_\_\_ Back pain                      Leg, buttock, or foot: \_\_\_ Pain        \_\_\_ Numbness \_\_\_ Weakness

\_\_\_ Other: \_\_\_\_\_

2. How long have you had this problem? \_\_\_\_\_

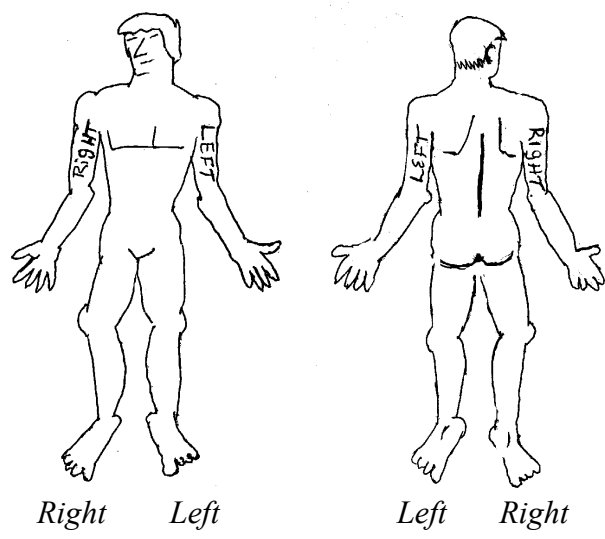
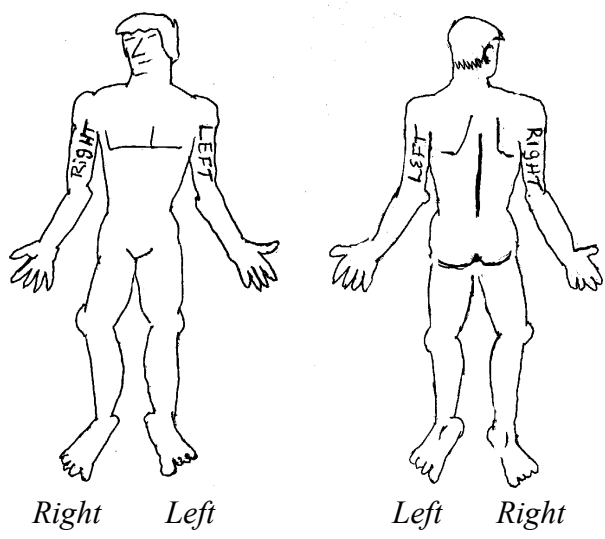
3. Has this problem recently gotten worse? YES / NO If YES, when? \_\_\_\_\_

4. What started the problem? \_\_\_\_\_

### B. Pain and Numbness Diagrams

Mark where you have PAIN

Mark where you have NUMBNESS or TINGLING



My pain level is (circle one): 0    1    2    3    4    5    6    7    8    9    10  
None    Slight    Moderate    Severe    Extreme    Could not be worse

### C. Complete this section for NECK/ARM problems ONLY.

1. What portion of your pain is in your **NECK versus your ARM(s)**? (Check only one)

- No neck or arm pain                       NECK and ARM pain are about equal (50/50)  
 All NECK pain, no arm pain               Mostly ARM pain, only some neck pain  
 Mostly NECK pain, some arm pain         All ARM pain, no neck pain

2. What portion of your **ARM PAIN** is on the **RIGHT versus LEFT**? (Check only one)

- No arm pain                                       RIGHT and LEFT arms are about equal (50/50)  
 RIGHT arm pain, no left arm pain         Mostly LEFT arm pain, some right arm pain  
 Mostly RIGHT arm pain, some left arm pain    LEFT arm pain, no right arm pain

3. If you have **ARM PAIN**, where do you feel it? (Check all that apply)

- RIGHT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small  
LEFT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small

4. If you have **ARM NUMBNESS**, where do you feel it? (Check all that apply)

- RIGHT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small  
LEFT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small

5. If you have **ARM WEAKNESS**, where do you feel it? (Check all that apply)

- RIGHT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small  
LEFT:  Shoulder    Arm    Forearm   FINGERS:  Thumb    Index    Long    Ring    Small

6. Are you **right- or left-handed**? (Circle one)              **RIGHT**              **LEFT**

7. Please indicate which, if any, of these problems you are experiencing. (Check all that apply)

- Pain or numbness that is *worse at night* than during the day  
 Pain or numbness that is *worse with overhead activity* (e.g., washing or drying hair)  
 Difficulty *picking up small objects* (e.g., keys, coins) or *buttoning shirts*  
 New difficulty with *handwriting or penmanship*  
 Problems with *balance or frequent tripping*  
 Headaches in the *back of the head*

## D. Complete this section for BACK/LEG problems ONLY.

1. What portion of your pain is in your **BACK versus your LEG(s)**? (Check only one)

- No back or leg pain                       BACK and LEG pain are about equal (50/50)  
 All BACK pain, no leg pain               Mostly LEG pain, only some back pain  
 Mostly BACK pain, some leg pain         All LEG pain, no back pain

2. What portion of your **LEG PAIN** is on the **RIGHT versus LEFT**? (Check only one)

- No leg pain                                       RIGHT and LEFT legs are about equal (50/50)  
 RIGHT leg pain, no left leg pain         Mostly LEFT leg pain, some right leg pain  
 Mostly RIGHT leg pain, some left leg pain  LEFT leg pain, no right leg pain

3. If you have **LEG PAIN**, where do you feel it? (Check all that apply)

- RIGHT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot  
LEFT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot

4. If you have **LEG NUMBNESS**, where do you feel it? (Check all that apply)

- RIGHT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot  
LEFT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot

5. If you have **LEG WEAKNESS**, where do you feel it? (Check all that apply)

- RIGHT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot  
LEFT:  Buttock  Groin  Front of thigh  Side of thigh  Back of thigh  Calf  Foot

6. How far can you walk before **LEG PAIN** makes you stop and rest? (Check only one)

- I cannot stand up                               1 or 2 blocks  
 Across the room                                 1 or 2 miles  
 Across the parking lot                         I can walk as far as I want without leg pain

7. Is there anything else that keeps you from **WALKING** very far? (Check all that apply)

- Back pain                                               Shortness of breath  
 Chest pain                                             Poor balance

8. What happens to your **LEG PAIN** with the following activities? (Check all that apply)

- Lying down:*  Better  Worse  No change      *Walking:*  Better  Worse  No change  
*Sitting:*  Better  Worse  No change      *Bend forward:*  Better  Worse  No change  
*Standing:*  Better  Worse  No change      *Bend back:*  Better  Worse  No change

9. What happens to your **BACK PAIN** with the following activities? (Check all that apply)

*Lying down:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change     *Walking:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change  
*Sitting:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change     *Bend forward:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change  
*Standing:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change     *Bend back:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change  
*Coughing:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change     *Sneezing:* \_\_\_ Better \_\_\_ Worse \_\_\_ No change

**E. All patients should answer the following questions.**

- 1. Are you **RECENTLY** leaking either urine or stool? **YES / NO** If YES, since when? \_\_\_\_\_
- 2. Are you **RECENTLY** straining to urinate? **YES / NO** If YES, since when? \_\_\_\_\_
- 3. Have you missed any work/school due to this problem? **YES / NO** How much? \_\_\_\_\_

4. Treatments for this particular problem have included: (Check all that apply)

___ Supervised physical therapy	___ Anti-inflammatory medication
Where? _____	___ Narcotic pain medication
___ Manipulation or chiropractic treatment	___ Epidural steroid injections: _____ times
Where? _____	How long did relief last? _____
___ Daily neck/back exercises	___ Facet joint injections/ablations: _____ times
___ Massage and ultrasound	How long did relief last? _____
___ Traction, VAX-D, or DRX-9000	___ Trigger point injections: _____ times
___ TENS unit or RS muscle stimulator	How long did relief last? _____
___ Back brace or neck collar	___ Other: _____

5. List pain medicines and dose taken for this problem: \_\_\_ NONE \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Previous doctors seen specifically about this problem: \_\_\_ NONE

<u>Doctor's Name</u>	<u>Specialty</u>	<u>City (if not Rockford)</u>	<u>Treatments</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. What tests have you had for your problem? Please list the most recent date and location. \_\_\_ NONE

X-rays _____	MRI _____
Myelogram _____	EMG _____
CT scan _____	Bone scan _____

**F. Past Medical History (Check all that apply) \_\_\_NONE**

- |                                              |                                              |                                              |                                                 |
|----------------------------------------------|----------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> HIV/AIDS               |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Chronic bronchitis  | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Heart failure       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Stomach ulcers      | <input type="checkbox"/> Fibromyalgia           |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia, frequent | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatoid arthritis   |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Gout                   |
| <input type="checkbox"/> Vascular disease    | <input type="checkbox"/> Dialysis            | <input type="checkbox"/> Seizure disorder    | <input type="checkbox"/> Lupus                  |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Kidney stones       | <input type="checkbox"/> Polio               | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Organ transplants   | <input type="checkbox"/> Blood clot in legs  | <input type="checkbox"/> Neuropathy          | <input type="checkbox"/> Cancer of _____        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Blood clot in lungs | <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Injury of _____        |
| <input type="checkbox"/> How long? _____     | <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> OTHER: _____           |

**G. Past Surgical History (List all previous surgeries, especially any surgeries on neck, chest, or back; write on back if needed) \_\_\_NONE**

Operation	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**H. Review of Systems (Check all that apply) \_\_\_NONE**

- |                                                        |                                                 |                                                 |                                                    |
|--------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <b>PATHOLOGIC</b>                                      | <b>PULMONARY</b>                                | <input type="checkbox"/> Double vision          | <input type="checkbox"/> New moles/dark spots      |
| <input type="checkbox"/> Fevers or chills              | <input type="checkbox"/> Wheezing               | <input type="checkbox"/> Frequent headaches     | <b>CONSTITUTIONAL</b>                              |
| <input type="checkbox"/> Night sweats                  | <input type="checkbox"/> Persistent cough       | <input type="checkbox"/> Blackouts or seizures  | <input type="checkbox"/> Frequent infections       |
| <input type="checkbox"/> Pain worse at night           | <input type="checkbox"/> Green/yellow sputum    | <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Gum or tooth problems     |
| <input type="checkbox"/> Unusual weight loss           | <input type="checkbox"/> Sinus infections       | <input type="checkbox"/> Loss of hearing        | <input type="checkbox"/> Anorexia or bulimia       |
| <input type="checkbox"/> Sudden weight gain            | <input type="checkbox"/> Bad or loud snoring    | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Poor nutrition            |
| <input type="checkbox"/> No position of relief         | <input type="checkbox"/> Frequent hoarseness    | <input type="checkbox"/> Nervous exhaustion     | <input type="checkbox"/> Very low energy           |
| <input type="checkbox"/> Pain no better with rest      | <input type="checkbox"/> Singing professionally | <input type="checkbox"/> Depression or anxiety  | <b>GENITOURINARY</b>                               |
| <input type="checkbox"/> Feel lump in buttock          | <b>GASTROINTESTINAL</b>                         | <b>HEMATOLOGIC</b>                              | <input type="checkbox"/> Swollen lymph glands      |
| <input type="checkbox"/> Feel lump in abdomen          | <input type="checkbox"/> Difficulty swallowing  | <input type="checkbox"/> Frequent nose bleeds   | <input type="checkbox"/> Difficulty urinating      |
| <b>CARDIOVASCULAR</b>                                  | <input type="checkbox"/> Nausea or vomiting     | <input type="checkbox"/> Easy bruising/bleeding | <input type="checkbox"/> Burning on urination      |
| <input type="checkbox"/> Heart or chest pain           | <input type="checkbox"/> Frequent diarrhea      | <input type="checkbox"/> Gums bleed easily      | <input type="checkbox"/> Frequent urination        |
| <input type="checkbox"/> Abnormal heartbeat            | <input type="checkbox"/> Blood in stool         | <input type="checkbox"/> Blood clots in legs    | <input type="checkbox"/> Blood in urine            |
| <input type="checkbox"/> Swollen ankles or feet        | <input type="checkbox"/> Very dark or tar stool | <input type="checkbox"/> Blood clots in lungs   | <input type="checkbox"/> Leaking urine             |
| <input type="checkbox"/> Freq. night urination         | <input type="checkbox"/> Ulcers                 | <b>RHEUMATOLOGIC</b>                            | <b>WOMEN ONLY:</b>                                 |
| <input type="checkbox"/> Poor circulation              | <b>NEUROLOGIC</b>                               | <input type="checkbox"/> Bad morning stiffness  | <input type="checkbox"/> Irregular periods         |
| <input type="checkbox"/> Short of breath if flat       | <input type="checkbox"/> Burning pain           | <input type="checkbox"/> Red or swollen joints  | <input type="checkbox"/> Vaginal discharge         |
| <input type="checkbox"/> Short of breath with exercise | <input type="checkbox"/> Shingles/herpes zoster | <input type="checkbox"/> Broken collarbone      | <input type="checkbox"/> Breast lumps or discharge |
|                                                        | <input type="checkbox"/> Change of vision       | <input type="checkbox"/> Rashes or skin changes |                                                    |

Have you ever had an infection with drug-resistant bacteria, e.g., methicillin-resistant staphylococcus (MRSA) or vancomycin-resistant enterococcus (VRE)? **YES / NO**

**I. Family History (Check all that apply) \_\_\_NONE \_\_\_UNKNOWN**

- |                                               |                                              |                                             |                                             |
|-----------------------------------------------|----------------------------------------------|---------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Severe neck problems | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Alcohol dependence |
| <input type="checkbox"/> Severe back problems | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Kidney failure     | <input type="checkbox"/> Mental illness     |

**J. Medications (List dose and schedule, write on back if needed) \_\_\_ NONE**

Any blood thinners (inc. aspirin)? **YES / NO**

Any cholesterol-lowering medicines? **YES / NO**

List: \_\_\_\_\_

List: \_\_\_\_\_

Any osteoporosis medicines? **YES / NO**

Are you taking calcium and vitamin D? **YES / NO**

List: \_\_\_\_\_

List: \_\_\_\_\_

OTHER: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**K. Allergies to Medications \_\_\_ NONE**

Medication

Type of Reaction (i.e., what happens?)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any allergy to latex or bananas? **YES / NO**

Any allergy to nickel or metals/jewelry? **YES / NO**

**L. Social History:**

1. Work status: \_\_\_ Homemaker \_\_\_ Student \_\_\_ Working (list occupation): \_\_\_\_\_  
\_\_\_ Retired \_\_\_ Sick leave \_\_\_ Not working  
\_\_\_ On long-term disability or SSI \_\_\_ Applying for long-term disability or SSI

2. Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Co-habiting  
\_\_\_ Divorced \_\_\_ Widowed

3. Number of living children: \_\_\_\_\_ Number of children living locally: \_\_\_\_\_

4. I live: \_\_\_ Alone I live with: \_\_\_\_\_

5. Tobacco use: \_\_\_ Never \_\_\_ Cigarettes \_\_\_ Cigars \_\_\_ Pipe \_\_\_ Chew  
\_\_\_ Packs per day for \_\_\_\_\_ years \_\_\_ I QUIT using tobacco \_\_\_ years ago

6. Alcohol use: \_\_\_ Never \_\_\_ # of drinks per day \_\_\_ # of drinks per week  
\_\_\_ Alcoholic (drunk daily) \_\_\_ Recovering alcoholic

7. Drug use: \_\_\_ Never \_\_\_ Currently \_\_\_ Past \_\_\_ Former addict/rehab patient

8. Because of this problem, I HAVE FILED a: \_\_\_ Lawsuit \_\_\_ Workers' compensation claim

9. Because of this problem, I MAY / WILL FILE a: \_\_\_ Lawsuit \_\_\_ Workers' compensation claim

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Pediatric and Adolescent Scoliosis/Kyphosis Questionnaire

Only fill out this form if you are seeing the doctor for SCOLIOSIS or KYPHOSIS.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ ft. \_\_\_\_\_ in. WEIGHT: \_\_\_\_\_ lbs.

Approximate growth in last 6 months: \_\_\_\_\_

Height of mother: \_\_\_\_\_

Height of father: \_\_\_\_\_

Height of siblings: \_\_\_\_\_

Any relatives with scoliosis/kyphosis? \_\_\_\_\_

How was scoliosis/kyphosis discovered? \_\_\_\_\_

Previous treatment for scoliosis/kyphosis \_\_\_\_\_

Previous surgeons seen for condition: \_\_\_\_\_

Have you had your first menses/period? **YES / NO** Approximate start date? \_\_\_\_\_

Are your menses/periods regular? **YES / NO**

How old was your mother when her menses/periods began? \_\_\_\_\_

How do you feel about how: **0 1 2 3 4 5 6 7 8 9 10**  
your spine looks? No problem Somewhat unhappy Very unhappy