OrthoNebraska Spine Center New Patient Questionnaire

Date: ____

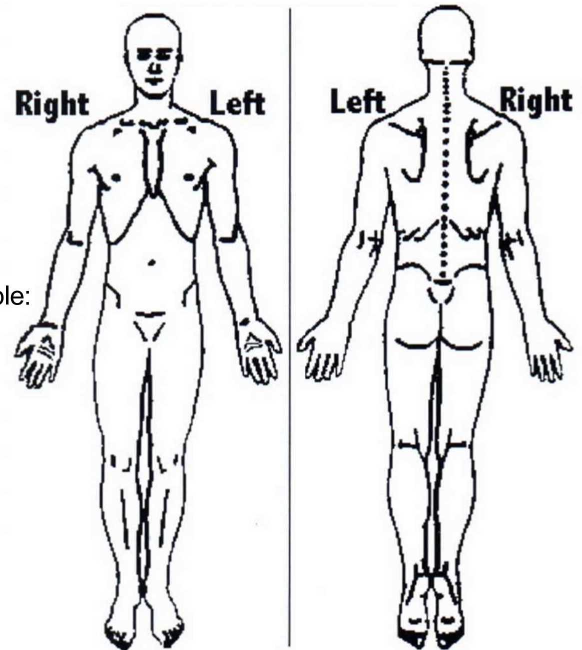
Name: ______________________________ Date of Birth__________________

Primary Care Physician: ____

Referring Physician: ____

What is the main reason for today's visit? ____________________________________

1. On the diagram to the right, please place an “X” where your pain starts.



2. If your pain radiates, draw an arrow on the diagram over the area the pain radiates.
3. When did your pain start?
   Date: ________
4. Please describe how your pain started in as much detail as possible:
5. Did your pain start (circle one):
   Suddenly / Gradually
6. Have your symptoms been (circle one):
   Improving / Unchanged / Worsening
7. Are your symptoms (circle one):
   Constant / Intermittent
8. Circle the most consistent descriptors below that describe your pain:
   Sharp / Dull / Achy / Burning / Numbness / Tingling / Cramping / Stiff
9. What makes your pain worse:
   Sitting / Standing / Walking / Bending / Lying down / Exercise / Other:_____
10. What is your pain today on a scale of 0-10 (0 meaning no pain; 10 meaning the worst imaginable pain)?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
11. What is your pain at its worst on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
12. What is your pain at its best on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
13. What is your pain on an average day on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

14. Have you experienced:

Fevers:	YES	NO	
Weight loss:	YES	NO	
Vision changes:	YES	NO	
Headaches:	YES	NO	
Chest pain:	YES	NO	
Shortness of breath:	YES	NO	
Loss of bowel control:	YES	NO	
Loss of bladder control:	YES	NO	
Rashes:	YES	NO	
Weakness:	YES	NO	If yes, where: _______
Numbness and/or Tingling:	YES	NO	If yes, where: _______
Depressed mood:	YES	NO	
Anxiety:	YES	NO	
Sleep problems:	YES	NO	
Other joint swelling:	YES	NO	
Pregnant or breast feeding:	YES	NO	

15. Is there litigation pending on this injury: YES NO
16. Was this injury a result of a motor vehicle accident? YES NO
17. Was this injury work related? YES NO

18. Do you have an allergy or adverse reaction to:
    - Contrast: YES NO
        - If yes, describe the reaction: ____________________________
    - Iodine: YES NO
        - If yes, describe the reaction: ____________________________
    - Betadine: YES NO
        - If yes, describe the reaction: ____________________________
    - Lidocaine: YES NO
        - If yes, describe the reaction: ____________________________
    - Steroids: YES NO
        - If yes, describe the reaction: ____________________________

19. Do you take any of the following medications:

Coumadin (warfarin)	YES	NO
Aspirin 325 mg	YES	NO
Plavix (clopidogrel)	YES	NO
Effient (prasugrel)	YES	NO
Pradaxa (dabigatran etexilate)	YES	NO
Eliquis (apixaban)	YES	NO
Aggrenox (aspirin/dipyridamole)	YES	NO
Trental (pentoxifylline)	YES	NO
Xarelto (rivaroxaban)	YES	NO
Glucophage (metformin)	YES	NO
Janumet (sitagliptin/metformin)	YES	NO

20. Have you ever had any of the following diagnostic studies to evaluate your pain (please bring reports and images to your clinic visit for review by the physician):
    - X-Rays: YES NO
        - Date completed: __/__/____
        - Results:
    - MRI: YES NO
        - Date completed: __/__/____
        - Results:
    - EMG: YES NO
        - Date completed: __/__/____
        - Results:

21. Please list any of the following treatments that you have had for this injury:

Physical therapy: YES NO
If yes, when and where? ____

Chiropractor: YES NO
If yes, when and where? ____

Acupuncture: YES NO
If yes, when and where? ____

Massage: YES NO
If yes, when and where? ____

Other: YES NO
If yes, what, when and where? ____

Pain medications:

Medication: _______ Dose: _____ Frequency: __________ Helpful: YES/NO

Medication: _______ Dose: _____ Frequency: __________ Helpful: YES/NO

Medication: _______ Dose: _____ Frequency: __________ Helpful: YES/NO

Medication: _______ Dose: _____ Frequency: __________ Helpful: YES/NO

Medication: _______ Dose: _____ Frequency: __________ Helpful: YES/NO

Previous Spine Surgeries:

Surgeon: ______________________ Date of surgery: ________
Name and location of surgery performed:________________________________

Surgeon: ______________________ Date of surgery: ________
Name and location of surgery performed: ________________________________

Surgeon: ______________________ Date of surgery: ________
Name and location of surgery performed: ________________________________

Previous Spine Injections:

Physician: ______________________ Date of surgery: ________
Name and location of injection performed: ________________________________

Physician: ______________________ Date of surgery: ________
Name and location of injection performed: ________________________________

Physician: ______________________ Date of surgery: ________
Name and location of injection performed: ________________________________

Immunizations

COVID-19 Vaccine	Series Started	Series Completed	Unknown	Declined
Flu Vaccine	Received during current flu season	Not received during current flu season		Unknown
Pneumonia Vaccine	Received less than 5 years ago	Received greater than 5 years ago	Not received	Unknown

Thank you very much for your time. This information may be helpful in diagnosing and managing your health care concerns.