OrthoNebraska Spine Center New Patient Questionnaire

Date: _____

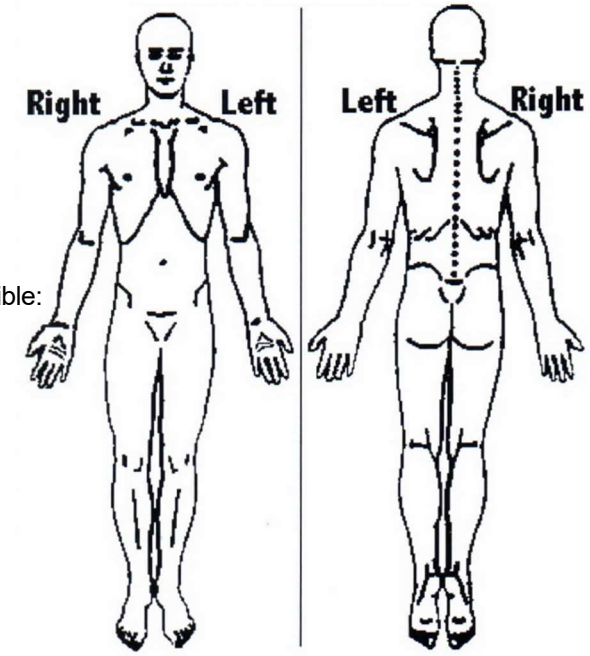
Name: _____ Date of Birth_____

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)?
    Please Select 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?
    Please Select 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?
    Please Select 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?
    Please Select 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: _____

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