# OrthoNebraska Spine Center Return Patient Questionnaire

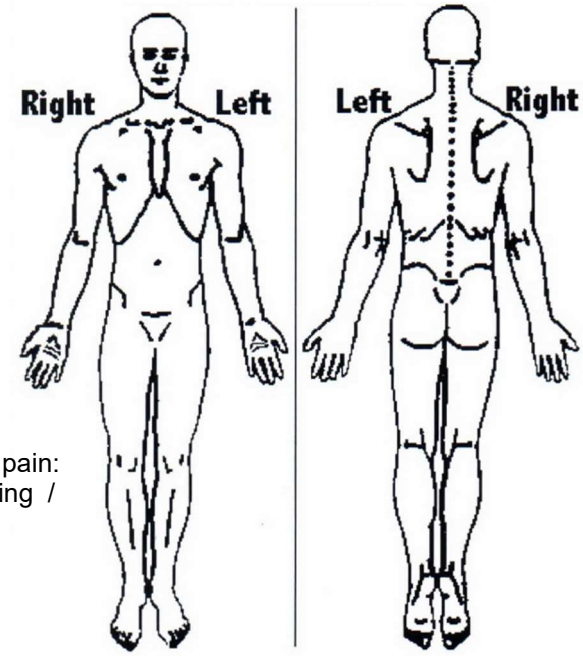
Date: _____

Name: _____ Date of Birth _____

Primary Care Physician: _____

Referring Physician: _____

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




1. Since your last visit, is your pain:
   ○ Better ○ Worse ○ Unchanged

   If you answered better, provide a percentage of improvement: __%

2. On the diagram to the right, please place an "X" where your pain starts.

3. If your pain radiates, draw an arrow on the diagram over the area the pain radiates.

4. Circle the most consistent descriptors below that describe your pain:
   ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Numbness ☐ Tingling ☐ Cramping / ☐ Stiff

5. What makes your pain worse:
   ☐ Sitting ☐ Standing ☐ Walking ☐ Bending /
   ☐ Lying down ☐ Exercise ☐ Other:_____

6. 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

7. 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

8. 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

9. 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

10. Have you experienced:

| | | | |
|---|---|---|---|
| Fevers: | ☐ YES | NO | |
| Headaches: | ☐ 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 | |
| Pregnant or breast feeding: | ☐ YES | NO | |

11. Since our last visit, have there been any changes to your overall medical health: ○YES ○NO

If yes, please describe any changes: _____

_____

_____

_____

_____

**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.*