Northwest Neurosurgical Associates, LLC
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Date Completed:_____

NAME: _____ AGE: ___ DOB: _____ Appointment Date:_____

REFFERING DR: _____ PRIMARY DR:_____

History of Present Illness

When (month/year) did your spine problem first begin? _____

Under what circumstances did your pain first begin?:

Accident at work	□ Yes	□ No
Accident away from work	□ Yes	□ No
Motor Vehicle Accident	□ Yes	□ No
Sports	□ Yes	□ No
Unknown cause	□ Yes	□ No

If your pain began from an injury at work, have you filled out a Worker's Compensation Claim?

If you were injured, did it involve:

Accident at work	□ Yes	□ No
Accident away from work	□ Yes	□ No
Motor Vehicle Accident	□ Yes	□ No
Sports	□ Yes	□ No
Unknown cause	□ Yes	□ No

Did any of your present symptoms exist before your injury? □ Yes, □ No

Please mark the sentence that best describes the effect of your condition/injury on your work:

- □ I have missed no work because of this condition
- □ I have missed work, but I am now back at light duty.
- □ I have missed work, but I am now back without limitation.
- □ I have been off work since: (please give date) _____

Are your symptoms: □ increasing □ decreasing □ staying the same

Is your pain: □ constant or ⌐ intermittent

Do any of the following make your symptoms better?:

□ lying down □ sitting □ standing □ walking □ other _____

Do any of the following make your symptoms worse?:

□ lying down □ sitting □ standing □ walking □ other _____

Do you have any problems controlling your bowel and/or bladder? □ Yes, □ No

Do you have any weakness? □ Yes, □ No

If yes, label the pain diagram (page 3) where you are weak

If yes, is it: □ increasing □ decreasing □ staying the same

Do you have any numbness? □ Yes, □ No

If yes, label the pain diagram (page 3) where you are numb

If yes, is it: □ increasing □ decreasing □ staying the same

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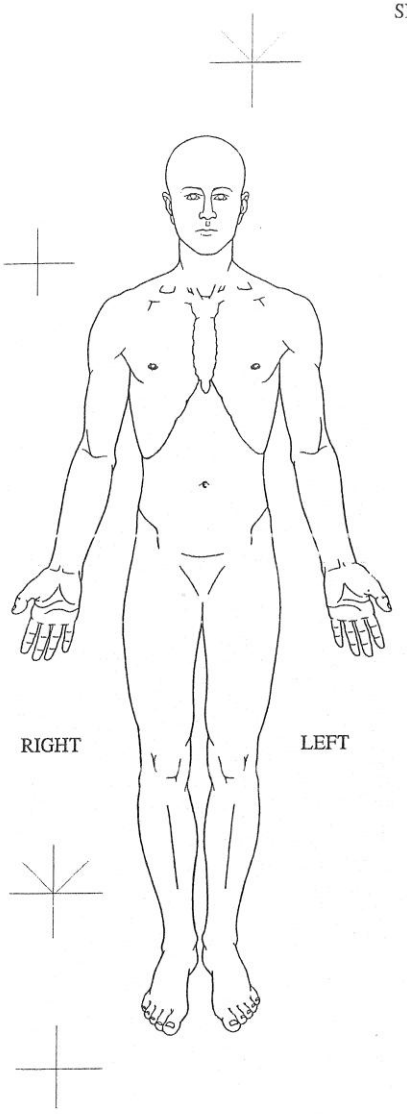
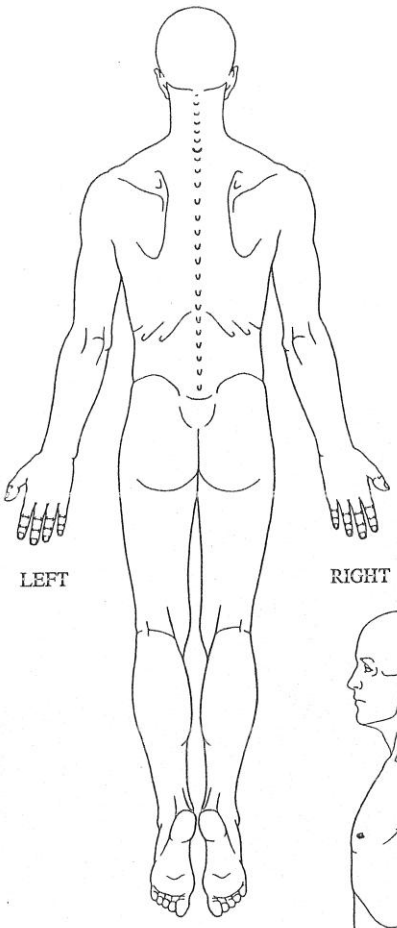
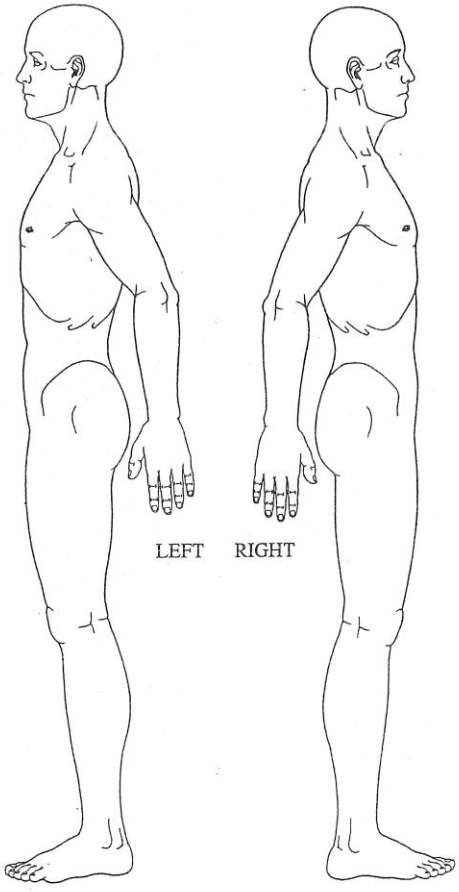
Mark the location of your symptoms on the diagram below:

SP







Grip Strength (R) (L)

IMP

(R) (L)

___ ° ___ Ext.

___ ° ___ Flex.

___ ° ___ Pro.

SP

SLP

NAME: _____

DATE: _____

HEIGHT: _____ WEIGHT: _____

RED: PAIN
GREEN: NUMBNESS & TINGLING

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Please Read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please just check the one choice which closely describes your problem right now**

SECTION 1--Pain Intensity
1. □ The pain comes and goes and is very mild.
2. □ The pain is mild and does not vary much.
3 □ The pain comes and goes and is moderate.
4 □ The pain is moderate and does not vary much.
5 □ The pain is severe but comes and goes.
6 .□ The pain is severe and does not vary much.

SECTION 2--Personal Care
1. □ I would not have to change my way of washing or dressing in order to avoid pain.
2. □ I do not normally change my way of washing or dressing even though it causes some pain.
3. □ Washing and dressing increase the pain, but I manage not to change my way of doing it.
4. □ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
5. □ Because of the pain, I am unable to do any washing and dressing without help.
6. □ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting
1. □ I can lift heavy weights without extra pain.
2. □ I can lift heavy weights, but it causes extra pain.
3. □ Pain prevents me from lifting heavy weights off floor.
4. □ Pain prevents me from lifting heavy weights off floor, but I can manage if they are conveniently positioned.
5. □ Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are convenient.
6. □ I can only lift very light weights, at the most.

SECTION 4 --Walking
1. □ Pain does not prevent me from walking any distance.
2. □ Pain prevents me from walking more than one mile.
3. □ Pain prevents me from walking more than 1/2mile.
4. □ Pain prevents me from walking more than 1/4 mile.
5. □ I can only walk while using a cane or on crutches.
6. □ I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
1. □ I can sit in any chair as long as I like without pain.
2. □ I can only sit in my favorite chair as long as I like.
3. □ Pain prevents me from sitting more than one hour.
4. □ Pain prevents me from sitting more than 1/2 hour.
5. □ Pain prevents me from sitting more than ten minutes.
6. □ Pain prevents me from sitting at all

SECTION 6 – Standing
1. □ I can stand as long as I want without pain
2. □ I have some pain while standing, but it does not increase with time
3. □ I can't stand for longer than 1 hour without increasing pain.
4 □ I can't stand for longer than ½ hour without increasing pain.
5. □ I can't stand for more than 10 minutes without increasing pain
6. □ I avoid standing because it increases pain right away.

SECTION 7--Sleeping
1. □ I get no pain in bed.
2. □ I get pain in bed, but it does not prevent me from sleeping.
3. □ Because of pain , my normal night's sleep is reduced by less than one-quarter.
4. □ Because of pain, my normal night's sleep is reduced by less than one-half.
5. □ Because of pain, my normal night's sleep is reduced by less than three-quarters.
6. □ Pain prevents me from sleeping at all.

SECTION 8--Social Life
1. □ My social life is normal and gives me no pain.
2. □ My social life is normal, but increases the degree of my pain
3. □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
4. □ Pain has restricted my social life and I do not go out very often.
5. □ Pain has restricted my social life to my home.
6. □ Pain prevents me from sleeping at all.

SECTION 9--Traveling
1. □ I get no pain while traveling.
2. □ I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. □ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4. □ I get extra pain while traveling which compels me to seek alternative forms of travel.
5. □ Pain restricts all forms off travel.
6. □ Pain prevents all forms of travel except that done lying down

SECTION 10--Changing Degree of Pain
1. □ My pain is rapidly getting better.
2. □ My pain fluctuates, but overall is definitely getting better.
3. □ My pain seems to be getting better, but improvement is slow at present.
4 . □ My pain is neither getting better nor worse.
5. □ My pain is gradually worsening.
6. □ My pain is rapidly worsening

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Please list any doctors that you have seen for this spine problem:

1._____ 4. _____
2._____ 5. _____
3._____ 6. _____

Physical Therapy □ never tried □ yes Last appointment _____
Where:_____

What treatment was performed?
□ exercises □ stretching □ TENS unit □ ultrasound □massage
□ helpful □ not helpful

Spine Injections

Type of Injection	Date	Doctor	Helpful
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No

Acupuncture □ never tried □ yes □ helpful □ not helpful
Last treatment _____ Where_____

Chiropractics □ never tried □ yes □ helpful □ not helpful
Last treatment _____ Where_____

Naturopath □ never tried □ yes □ helpful □ not helpful
Last treatment _____ Where_____

Please list any spine surgeries below: ☐ None

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MEDICAL HISTORY

□ GERD	□ emphysema	□ lung disease
□ heart failure	□ gout	□ fibromyalgia
□ asthma	□ thyroid diseaes	□ HIV
□ high blood pressure	□ depression	□ Anxiety
□ cancer	□ diabetes	

□ Other: _____

Lumbar Surgery History:

Type of Surgery	Date	Surgeon	Helpful
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No

Cervical Surgery History:

Type of Surgery	Date	Surgeon	Helpful
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No
			□Yes □ No

Please check/list all operations: □ none

□ appendectomy	when: _____	□ eye surgery	when: _____
□ tonsillectomy	when: _____	□ heart surgery	when: _____
□ gall bladder removal	when: _____	□ hysterectomy	when: _____
□ knee arthroscopy	when: _____	□ prostate surgery	when: _____
□ knee replacement	when: _____	□ surgery for cancer	when: _____
□ hip replacement	when: _____	Type: _____	

Other:

□
□
□

Blood Products / Transfusions:

□ YES, if necessary I am able to be transfused with blood products
□ NO, if necessary I am not able to be transfused with blood products

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MEDICATIONS

CURRENT PAIN MEDICATIONS:

Medication	Dose	Number of pills in 24 hrs	Prescribing Doctor

Unprescribed pain medications:
□ never tried □ marijuana □ alcohol □ cocaine □ someone else's prescribed medication □ other

CURRENT NON-PAIN MEDICATIONS:

Medication	Amount	How often

Are you currently taking □ Aspirin, □ Motrin, □ Aleve, □ or any other anti-inflammatory? _____
Are you taking □ Coumadin □ Plavix □Aggrenox

Please check/list all medications that you are allergic to: □ NONE

Medication	Symptom
1.	
2.	
3.	
4.	

Are you allergic to iodine □ Yes □ No
Are you allergic to tape □ Yes □ No
Do you have any skin reactions to jewelry or metals? □ Yes □ No

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Review of Systems

Height: _____ Weight: _____

General

□ weight gain	□ weight loss	□ history of falls	□ dizziness
□ fever	□ sweats	□ chills	□ snoring
□ insomnia	□ hypersomnia(sleep a lot)		

Skin

□ rash	□change in mole	□ lumps	□ easy bruising
□ itching	□ change in nails	□ dryness	

Eyes

□ glasses	□ double vision	□ glaucoma	□ cataracts
□ pain	□ discharge		

Ears

□ pain	□ hearing loss	□ hearing aid	□ deafness
□ tinnitus (ringing)	□ discharge		

Nose

□ runny nose	□ discharge	□ nose bleeds

Mouth / Throat

□ difficulty swallowing	□ hoarseness	□ dentures	□ mouth sores
□dry mouth	□ bleeding		

Respiratory

□ dry cough	□ productive cough	□ bloody cough	□ tuberculosis
□ shortness of breath	□ pain with breathing	□ wheezing	□ pulmonary embolism

Heart/ Blood Vessel

□ heart attack	□ angina	□ high blood pressure	□ murmur
□ leg / foot swelling	□ varicose veins	□ rheumatic fever	□ blood clots

Gastrointestinal

□ abdominal pain	□ change in appetite	□ hepatitis	□ heartburn
□ indigestion	□ nausea	□ vomiting	□ constipation
□ diarrhea	□ change in bowel movements	□ hemorrhoids	

Urology

□ painful urination	□ frequent urination	□ blood in urine	□ night time urination
□ urgency	□ bladder infections	□ genital / STD infection	□ bladder control probs.

Hematologic

□anemia	□bleeding problem	□transfusions	□ transfusion reaction

Allergic / Endocrine

□food allergies	□hay fever

Neurologic/Psychiatric

□ tremors	□ seizures	□ memory problems	□ TIA
□ stroke	□ depression	□ headaches	□ anxiety
□ emotional problems	□ ADD/ADHD		

Men

□ difficulty with erection	□ prostate cancer	□prostate hypertrophy	□ vasectomy

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Social History

Current Marital Status: □ married □ single □ divorced □ widowed □ n/a

Number of Children: _____ Ages of Children: _____

Living Status: □ alone □ with spouse □ with parents □ with roommate □ assisted living
□ nursing home

Occupation:_____ How Long (yrs) ___ Previous Occupation:_____

Highest Education Level: □ grade school □ middle school □ high school □ college
□ post graduate

Do you use tobacco now or in the past? □ Yes, use now □ Never used
□ Previous user Quit ___ years ago

Cigarerettes: How many per day? _____ How many years? _____
Cigars: How many per day? _____ How many years? _____
Smokeless: How much per day? _____ How many years? _____
Nicotine: □ patch □ gum

Do you drink alcoholic beverages? □ Yes, □ No
Beer: How many per day? _____
Wine: How many glasses per day? _____
Other: How much per day? _____

Have you ever felt the need to cut down on drinking?	□ Yes	□ No
Have you ever felt annoyed by criticism of your drinking?	□ Yes	□ No
Have you ever felt guilty about your drinking?	□ Yes	□ No
Have you ever felt the need for a morning eye opener?	□ Yes	□ No

Have you ever had or been treated for a drug or alcohol dependency problem? □Yes □No

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Family History

Relative	Alive	Deceased	Health Problems
Father	□	□	
Mother	□	□	
Sibling 1	□	□	
Sibling 2	□	□	
Sibling 3	□	□	
Sibling 4	□	□	
Sibling 5	□	□	
Sibling 6	□	□	

Please check the box if anyone in your immediate family has had any of the following conditions (Note relationship):

□ Hypertension	□ father	□ mother	□ sister	□ brother
□ Heart Attack	□ father	□ mother	□ sister	□ brother
□ Diabetes	□ father	□ mother	□ sister	□ brother
□ Epilepsy	□ father	□ mother	□ sister	□ brother
□ Stroke	□ father	□ mother	□ sister	□ brother
□ Gout	□ father	□ mother	□ sister	□ brother
□ Kidney Disease	□ father	□ mother	□ sister	□ brother
□ Thyroid Disease	□ father	□ mother	□ sister	□ brother
□ Asthma	□ father	□ mother	□ sister	□ brother
□ Rheum. Arthritis	□ father	□ mother	□ sister	□ brother
□ Blood Disorder	□ father	□ mother	□ sister	□ brother
□ Cancer	□ father	□ mother	□ sister	□ brother
Cancer Type	□ breast	□ lung	□ colon	□ prostate □ skin □ other

Does anyone in your family have a spine problem? □ yes □ no

IF YES,

□ father □ mother □ sister □ brother

□ neck □ low back

Have they had surgery? □ yes □ no