

Sister Kenny Spine Center- Patient Questionnaire

Please print off, complete by hand, and bring with you to your appointment at Sister Kenny Spine Center.

Name _____

Date _____

DOB _____

1. Select ONE as your primary symptom.

1. Low back pain
2. Mid back pain
3. Neck pain
4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
6. Arm pain, numbness or tingling. Left Right or Both
7. Shoulder pain Left Right or Both
8. Headache
9. Other _____

2. In addition to your primary symptom noted above, what OTHER symptoms do you have?

1. Low back pain
2. Mid back pain
3. Neck pain
4. Leg pain, numbness or tingling that radiates BELOW the knee. Left Right or Both
5. Leg pain, numbness or tingling that does NOT go below the knee. Left Right or Both
6. Arm pain, numbness or tingling. Left Right or Both
7. Shoulder pain Left Right or Both
8. Headache
9. Other _____

3. What was the onset date of your symptoms or your injury? _____

4. Are your symptoms related to a Motor Vehicle Accident (MVA)? Yes No

If Yes, Date(s): _____

5. Are your symptoms recognized as a workers compensation injury? Yes No Undetermined

Please explain _____

Patient Sticker

6. Place an X by the treatments or diagnostic tests you have had for your spine symptoms.
- ___ Medications What type? Anti-inflammatory, Muscle relaxant, Medrol dose pack, Prednisone, Pain medications, other _____
- ___ Physical therapy (date) _____
- ___ Chiropractic care (date) _____
- ___ Massage
- ___ X-ray (date) _____
- ___ CT scan (date) _____
- ___ MRI scan (date) _____
- ___ Myelogram (date) _____
- ___ EMG (date) _____
- ___ Epidural steroid injection (date) _____
- ___ Diagnostic nerve block (date) _____
- ___ Other _____

7. Have you been referred to any other specialists for evaluation of your spine symptoms?

Yes No Please list _____

8. Have you had surgery on your **NECK**? Yes No On your **BACK**? Yes No
- Date of most recent **Neck** Surgery _____ Date of most recent **Back** Surgery _____

Name of Surgeon: _____

Name of Surgeon: _____

What type of **NECK** surgery:

- ___ Discectomy
- ___ Microdiscectomy
- ___ Laminectomy
- ___ Fusion
- ___ Other _____

What type of **BACK** surgery:

- ___ Discectomy
- ___ Microdiscectomy
- ___ Laminectomy
- ___ Fusion
- ___ Other _____

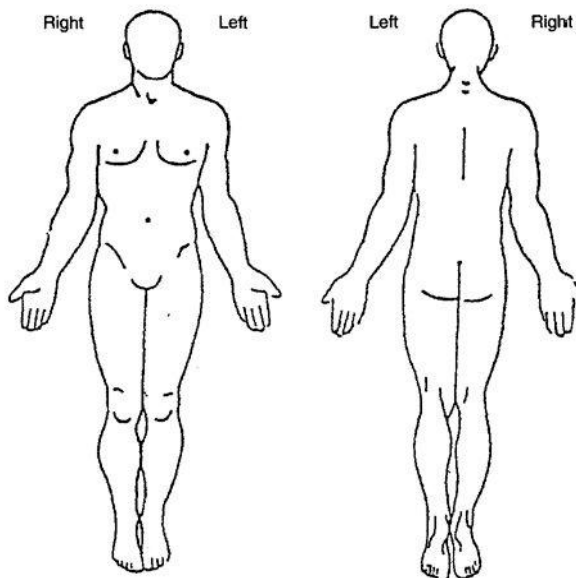
9. Symptom Assessment: Please rate your CURRENT symptoms: (0=no pain, 10= severe)

With regard to your Neck: 0 1 2 3 4 5 6 7 8 9 10

With regard to your Back: 0 1 2 3 4 5 6 7 8 9 10

Patient sticker

10. Mark areas of current symptoms.



11. Please note if the following improve or worsen your symptoms.

Improve	Worsen	Unchanged		Improve	Worsen	Unchanged	
_____	_____	_____	Sitting	_____	_____	_____	Laying down
_____	_____	_____	Standing	_____	_____	_____	Computer/Desk work
_____	_____	_____	Walking	_____	_____	_____	Cough/Sneeze/Strain
_____	_____	_____	Bending	_____	_____	_____	Lifting

12. Is this your first episode of pain or have you had recurrent episodes? First episode: Yes No
 Recurrent, how many? _____ Date of Most Recent Episode: _____

13. Please rate the quality of your sleep. ___Poor ___Fair ___Good ___Excellent
 Is your sleep disturbance related to your spine symptoms? Yes No

14. Work History: Current occupation _____
 Employer _____
 Are you currently working? Yes No
 Physical demands of work: ___Sedentary ___Mild ___Moderate ___Heavy
 Have you missed work due to your current symptoms? Yes No Please explain

Have you been given work restrictions by your physician? Yes No Please list

Have you been given a workers compensation disability rating in the past for your Spine symptoms? Yes No What was the rating? _____
 By whom? _____
 Don't know _____

Patient sticker

15. Past medical history: Current Medications _____

Do you have any medication allergies? Yes No Please list _____

Past Surgeries (other than spinal surgery, i.e. Joint Replacements, etc) _____

Have you been diagnosed with any of the following?

Yes	No		Yes	No	
_____	_____	Angina, heart disease	_____	_____	Diabetes
_____	_____	High blood pressure	_____	_____	Seizures
_____	_____	Respiratory disease, asthma, COPD	_____	_____	Cancer- Site _____
_____	_____	Osteoporosis	_____	_____	Other- List _____
_____	_____	Arthritis- Site: _____			

16. Social history: Marital status M S D W
Tobacco use Yes No
Height _____ Weight _____ Right handed or Left handed

What sports or recreational activities do you participate in? _____

Do you currently have legal representation? Yes No Case settled? Yes No
Do you have any concern about your physical or emotional safety at home? Yes No
If yes, please explain _____

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" (15 years old or older). Yes No

17. Family history: Are there any medical problems with the following family members?

Yes	No	If yes, please list
_____	_____	Mother _____
_____	_____	Father _____
_____	_____	Siblings _____

Patient sticker

18. Review of systems: Please note if you currently or recently have experienced any of the following.

Yes	No		If yes, please explain.
_____	_____	Fatigue	_____
_____	_____	Unexplained weight loss	_____
_____	_____	Fever or chills not related to a respiratory illness	_____
_____	_____	Night sweats	_____
_____	_____	Are you awakened at night by your spine pain?	_____
_____	_____	Anemia or easy bruising	_____
_____	_____	Visual disturbance, eye pain or redness	_____
_____	_____	Dizziness, ringing in ears, throat or ear pain	_____
_____	_____	Respiratory symptoms including wheezing or shortness of breath	_____
_____	_____	Chest pain, angina, chest heaviness or heart palpitations	_____
_____	_____	Abdominal pain, decreased appetite	_____
_____	_____	Nausea, vomiting, diarrhea, constipation	_____
_____	_____	Urinary problems including inability to empty bladder, incontinence	_____
_____	_____	Female patients- Are you pregnant?	_____
_____	_____	Skin rash, psoriasis	_____
_____	_____	Any recent trauma or joint injury	_____
_____	_____	History of broken bones	_____
_____	_____	Arthritis, joint inflammation	_____
_____	_____	Muscle aches	_____
_____	_____	Scoliosis	_____
_____	_____	Depression, anxiety, panic attacks	_____
_____	_____	Neurological problems including fainting, blackouts, memory loss	_____
_____	_____	Headaches	_____
_____	_____	Difficulty walking, severe arm or leg weakness	_____

How do you prefer to receive instructions on your care? (Circle One)

Reading Listening Demonstration

What goals or results do you wish to achieve by the end of your rehab here at Sister Kenny Spine Center? _____

Thank you for completing the Sister Kenny Spine Center patient questionnaire.

Comments _____

Patient Signature: _____

Date: _____ Therapist Initials: _____

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