Date_________________

The Orthopedic Sports Clinic

Neil Badlani M.D.

Spine Patient History Questionnaire

Name__________________________________ DOB__________ Age_______ Sex__________

Referred by______________________________ Height___________ Weight_____________

Chief Complaint/Main Problem____

Neck Pain (or numbness) Severity (1-10)______
□Neck pain worse than shoulder/arm pain
□Neck pain same as shoulder/arm pain
□Neck pain less than shoulder/arm pain
Which arm/shoulder? □Right □Left □Both

Back Pain (or numbness) Severity (1-10)_____
□Back pain worse than hip/leg pain
□Back pain same as hip/leg pain
□Back pain less than hip/leg pain
Which hip/leg? □Right □Left □Both

When did your problem start?_________________ Was the onset of pain? □Sudden □Gradual

Was this caused by? □Car accident □Fall □Work Injury Other_____________________________

What other doctors have you seen for this?____

Are you getting? □Better □Worse □Unchanged Pain is? □Constant □Intermittent

How far can you walk?___________________ How long can you sit?__________ stand?____________

Which INCREASES your pain (circle all that apply)?

Standing Sitting Walking Lying Exercise
Bending forward Bending backward Other______________________ ______________

Which DECREASES your pain (circle all that apply)?

Standing Sitting Walking Lying Exercise
Bending forward Bending backward Other______________________ ______________

What are your activity limitations because of pain? ____

Occupation/Employer____________________________________Are you currently working? □Yes □No

Is your job? □sedentary □light work □medium work □heavy labor

List previous spine surgeries you have had____

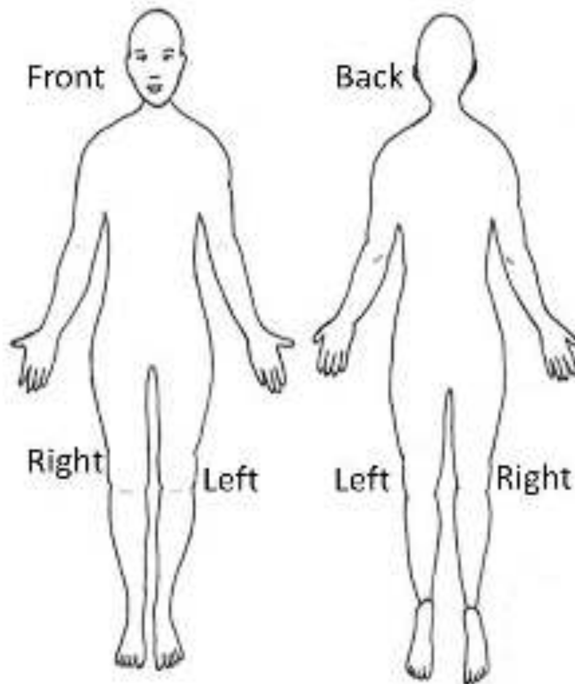
For your current problem, which imaging studies have you had?

□	Study	Date	Result
	X-rays		
	MRI		
	CT Scan		
	Myelogram		
	EMG		
	Bone Scan		
	Discogram		
	Other______________________		

For your current problem, which treatments have you had?

□	Treatment	Date	Pain relief? (Indicate none, mild, moderate or excellent and duration of relief)
	Medications___________________		
	Physical/Occupational Therapy		
	Injections (Epidural, facet, etc)		
	Brace or collar		
	Chiropractor		
	Other_______________________		

Pain Diagram- Please mark the areas on your body where you feel pain and other sensations.



Use these symbols and mark all affected areas

Ache- ^^^^^^

Numbness- :::::::::

Pins and Needles- ========

Burning- xxxxxxxx

Stabbing- ////////