

SPINE CENTER QUESTIONNAIRE
DR. CURYLO

TODAY'S DATE:...../...../.....

Your Name:.....

Your Age:.....

Family Doctor:.....

Who would you like a report sent to:.....

Please briefly describe your reason for this visit:.....

.....

When did your current problem start:.....

How did your current problem start:.....

.....

.....

PLEASE HELP US WITH A PAIN DIAGRAM

Draw the location of your pain on the body outlines below:

Check the boxes that best describe your pain:

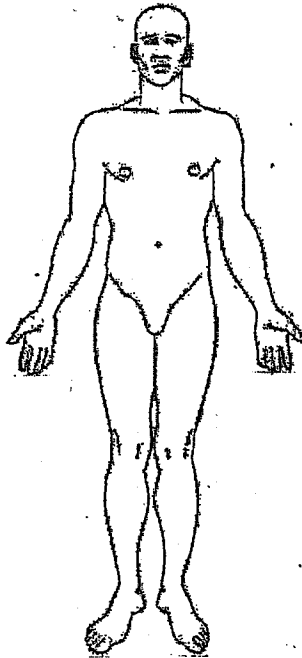
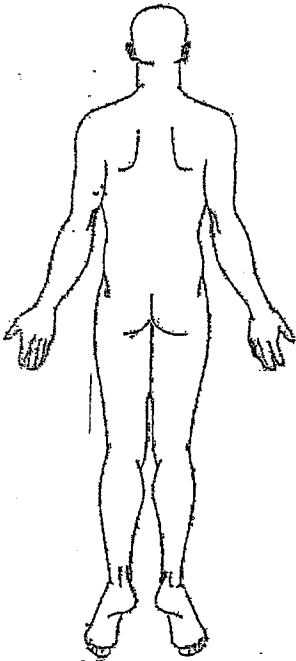
Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHING PINS & NEEDLES

 OOOOO

BURNING SHARP & STABBING
 XXXXX
 |||||

	None	Mild	Moderate	Severe
THROBBING				
SHOOTING				
STABBING				
SHARP				
CRAMPING				
GNAWING				
HOT-BURNING				
ACHING				
HEAVY				
TENDER				
SPLITTING				
TIRING/				
EXHAUSTING				
SICKENING				
FEARFUL				
PUNISHING/				
CRUEL				



1. % PAIN IN LOW BACK.....
 2. % PAIN IN RT. BUTTOCK.....
 3. % PAIN IN LT. BUTTOCK.....
 1. % PAIN IN RIGHT LEG.....
 3. % PAIN IN LEFT LEG.....
 3. % PAIN ELSEWHERE.....
- TO TOTAL 100%

How bad is your pain now?

-No Pain
-Mild
-Discomforting
-Distressing
-Horrible
-Excruciating

How often does your problem come on?.....

What makes your pain WORSE or BETTER?

	Worse	Better
Sitting		
Standing		
Walking		
Bending		
Lying Down		
Rest		
Coughing/Straining		
Neck Position		
Arm Position		
Ice		
Heat		

Which treatments have you used for current problem?

	Improved	Not Helpful
Physical Therapy		
Chiropractic		
Acupuncture		
Pain Clinic		
Spine Injections		
Spine Surgery		

Past Health Problems: Please list problems in the appropriate areas

- Head/Brain.....
- Eyes.....
- Ears, Nose, Throat.....
- Heart.....
- Lungs.....
- Stomach, Abdomen, Bowels.....
- Liver.....
- Kidney, Bladder.....
- Prostate or Sexual Organs.....
- Bones, Muscles, Joints.....
- Breasts.....
- Mental Problems.....
- Cancer.....
- Other.....

REVIEW OF SYSTEMS

PLEASE CIRCLE IF ANY PERTAIN AT THIS TIME:

- Constitutional symptoms:** Fever, chills fatigue or weight loss/gain of over 20 pounds
- Ear/Nose/Throat:** Hearing loss, sinusitis, hoarsness or vertigo
- Eyes:** Double vision, blurring or glasses
- Cardiovascular:** Chest pain or palpitations
- Respiratory:** Shortness of breath, asthma or chronic cough
- Stomach/Intestinal:** Appetite loss, nausea, diarrhea, constipation, heartburn or abdominal pain
- Urology:** Hesitancy, incontinence or burning urination
- Skin/Breast:** Rashes, lesions or scars
- Neurological:** Speech/swallowing problems, stroke, seizure or headaches
- Psychological:** Depression, hallucinations, sleep disturbances, alcoholism or drug addiction
- Endocrine:** Growth/hair changes, excess thirst or decreased energy
- Hematologic/Lymphatic:** Easy bruising, blood clots, bleeding disorders, anemia or swelling
- Allergic/Immunologic:** Food allergies, immune deficiency or frequent infections

PAST SURGERIES: (Please list each separately):

- 1.....
- 2.....
- 3.....

PAST SPINE SURGERIES:

- 1.....
- 2.....
- 3.....

ALLERGIES:

.....

.....

MEDICATIONS: (Please list ALL, including what dose and how often you take them):

.....

.....

.....

.....

.....

Your Family history:

Father: Living..... Deceased..... At what age?.....

Mother Living..... Deceased..... At what age?.....

Please list any family medical problems:.....

.....

SOCIAL QUESTIONS:

Do you smoke: YES..... NO.....

If yes how many packs per day?.....

How long have you been smoking?.....

Do you consume alcohol?..... How often:.....

Have you ever used drugs?.....

If yes, please list the drugs:.....

OCCUPATION QUESTIONS:

Are you currently working?.....

Your current job position:.....

What do you physically do at your job (ie: lift boxes).....

Your employer:.....

Have you lost time from your job due to the current problem?.....

Office Use Only

Reviewed with patient by:..... Date:.....

This questionnaire provides information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the box that best describes your condition.

During the past 4 weeks.....

1. Pain Intensity:

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief of pain.
- Pain medication provides me with moderate relief of pain.
- Pain medication provides me with little relief of pain.
- Pain medication has no effect on my pain.

2. Personal Care:

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed; I wash with difficulty, and stay in bed.

3. Lifting:

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting weights off the floor, but I can manage if the weights are conveniently positioned. (e.g., on a table)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

4. Walking:

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

5. Sitting:

- I can sit in a chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

6. Sleeping:

- My sleep is never disturbed by pain.
- I can only sleep well only using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

7. Standing:

- I can stand as long as I want without increased pain.
- I can stand as long as I want but it increases my pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than ½ hour.
- Pain prevents me from standing more than 10 min.
- Pain prevents me from standing at all.

8. Social Life:

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to home.
- I have hardly any social life because of my pain.

9. Traveling:

- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the Physician, therapist or hospital.

10. Changing Degree of Pain:

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

DISABILITY INDEX SCORE _____ %