

**SPINE CENTER QUESTIONNAIRE**

**TODAY'S DATE:**

**DR. CURYLO**

NAME: \_\_\_\_\_

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:

Mark the areas on your body where you feel the

described sensation. Use the appropriate symbol.

Mark areas of radiation. Include all affected areas.

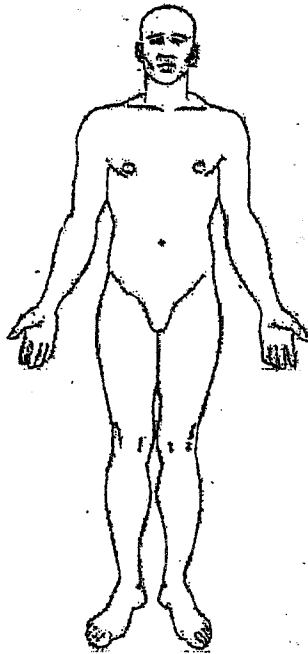
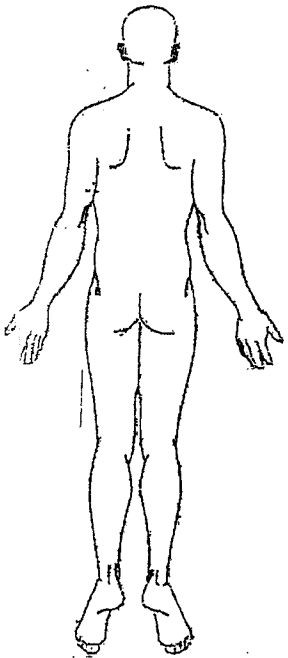
ACHING  
\*\*\*\*\*

PINS & NEEDLES  
OOOOO

BURNING  
XXXXX

SHARP & STABBING  
IIIII

**CHECK THE BOXES THAT BEST DESCRIBE YOUR PAIN:**



	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 \_\_\_\_\_
  - 4. % PAIN IN RIGHT LEG \_\_\_\_\_
  - 5. % PAIN IN LEFT LEG \_\_\_\_\_
  - 3. % PAIN ELSEWHERE \_\_\_\_\_
- TO TOTAL 100%**

**HOW BAD IS YOUR PAIN RIGHT 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 OR N/A**

- 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: YES \_\_\_\_\_ NO \_\_\_\_\_ How Often: \_\_\_\_\_  
Have you ever used drugs: YES \_\_\_\_\_ NO \_\_\_\_\_  
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? YES \_\_\_\_\_ NO \_\_\_\_\_

**Office Use Only**

Reviewed with patient by: \_\_\_\_\_ Date: \_\_\_\_\_