The SpineCare Center
Physician directed treatment and rehabilitation for pain relief.

VISIT QUESTIONNAIRE

Where did you first hear about us?

❑ Social Media ❑ Online Search ❑ SpineCare Website ❑ Billboard ❑ Magazine/Newspaper ❑ Family/Friend
❑ Yelp or other review website ❑ Physician Referral (Physician name) _____ ❑ Other _____

1. When did your pain first occur? _____ **2.** Is this admission/visit due to an accident/injury? ❑ No ❑ Yes

Date of Accident _____ Location of accident _____ Type of accident _____

3. If this is an injury/accident, are you represented by an attorney? ❑ No ❑ Yes Name _____

4. Who is your primary care physician? _____

5. Location(s) of your pain:_____

6. Have you had any of the following in your legs and/or feet:

	YES	NO	If you answered yes, where was it located?
Pain	❑	❑	❑ Right Leg ❑ Right Foot ❑ Left Leg ❑ Left Foot ❑ Both Legs ❑ Both Feet
Weakness	❑	❑	❑ Right Leg ❑ Right Foot ❑ Left Leg ❑ Left Foot ❑ Both Legs ❑ Both Feet
Numbness	❑	❑	❑ Right Leg ❑ Right Foot ❑ Left Leg ❑ Left Foot ❑ Both Legs ❑ Both Feet
Tingling	❑	❑	❑ Right Leg ❑ Right Foot ❑ Left Leg ❑ Left Foot ❑ Both Legs ❑ Both Feet

7. Have you had any of the following in your shoulders, arms and/or hands:

	YES	NO	If you answered yes, where was it located?
Pain	❑	❑	❑ Right Shoulder ❑ Right Arm ❑ Right Hand ❑ Left Shoulder ❑ Left Arm ❑ Left Hand ❑Both Shoulders ❑ Both Arms ❑ Both Hands
Weakness	❑	❑	❑ Right Shoulder ❑ Right Arm ❑ Right Hand ❑ Left Shoulder ❑ Left Arm ❑ Left Hand ❑Both Shoulders ❑ Both Arms ❑ Both Hands
Numbness	❑	❑	❑ Right Shoulder ❑ Right Arm ❑ Right Hand ❑ Left Shoulder ❑ Left Arm ❑ Left Hand ❑Both Shoulders ❑ Both Arms ❑ Both Hands
Tingling	❑	❑	❑ Right Shoulder ❑ Right Arm ❑ Right Hand ❑ Left Shoulder ❑ Left Arm ❑ Left Hand ❑Both Shoulders ❑ Both Arms ❑ Both Hands

8. Have you had any of the following:

	YES	NO		YES	NO		YES	NO
Loss of bowel control	❑	❑	Rash	❑	❑	Loss of bladder control	❑	❑

9. Mark any of the following that describe your pain or symptoms: ***Please document location of muscle spasms**

❑ mild	❑ occasional	❑ crushing	❑ occurring at rest	❑ stabbing	❑ intermittent	❑muscle spasms_____
❑ moderate	❑ aching	❑ dull	❑ pressure	❑ stinging	❑ cramping	
❑ severe	❑ activity related	❑ fullness	❑ sharp	❑ throbbing	❑ occurring at night	
❑ constant	❑ burning	❑ heaviness	❑ shooting	❑ tightening	❑ squeezing	

10. Please mark any of the following tests or studies you have had done for the problem that you are here for today:

❑ no work up	❑ CT myelogram	❑ Lab work	
❑ plain films	❑ MRI	❑ MRA	Where were they performed? _____
❑ CT scan	❑ EMG-NCV	❑ Bone Scan	

11. Have you tried any of the following treatments for the problem that you are here for today:

	Yes	Did it help?		Yes	Did it help?
nothing tried	❑	YES ❑	Over the Counter pain meds	❑	YES ❑
rest	❑	YES ❑	NSAIDs (such as Ibuprofen, Aleve, Advil, Etc.)	❑	YES ❑
ice	❑	YES ❑	narcotic pain meds	❑	YES ❑
heat	❑	YES ❑	chiropractic therapy	❑	YES ❑
acupuncture	❑	YES ❑	physical therapy	❑	YES ❑
Muscle relaxants	❑	YES ❑	When? _____		

12. Did you get any relief for any length of time after your last injection or nerve block? **YES ❑ NO ❑** If yes, what percent better? _____

13. Do you take a blood thinner? ❑ No ❑ Yes Name of Blood Thinner _____

14. **Who is driving you home? _____You must leave a contact phone #:_____**

Will this person be ❑ available within 10 minutes from The SpineCare Center or ❑ waiting in the waiting room?

15. Rate your pain by circling the number or words that best describes your pain:

At its ***WORST*** in the last month or since here last
No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
At its ***LEAST*** in the last month or since here last
No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
TODAY?
No pain 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

16. Circle the number or words that best describe how much pain interferes with your life.

No interference 1 2 3 4 5 6 7 8 9 10 Unable to do usual activities

17. Check when your pain is worse: ❑ Morning ❑ Afternoon ❑ Evening ❑ Night or ❑ No typical pattern

18. Sleep: Average number of hours per night: _____ Sleep quality ❑ Good ❑ Fair ❑ Poor

Do you **currently** have any of the following symptoms or problems with:

	YES	NO	If Yes, please explain below:
General:			
fever	☐	☐	
chills	☐	☐	
fatigue	☐	☐	
weight gain	☐	☐	
weight loss	☐	☐	
HEENT:			
vision problems	☐	☐	
hearing problems	☐	☐	
speech problems	☐	☐	
Skin:			
open wounds	☐	☐	
rash	☐	☐	
lesions	☐	☐	
Cardiac:			
chest pain	☐	☐	
Pulmonary:			
cough	☐	☐	
wheezing	☐	☐	
shortness of breath	☐	☐	
GI:			
nausea	☐	☐	
vomiting	☐	☐	
diarrhea	☐	☐	
loss of bowel control	☐	☐	
GU:			
difficulty urinating dysuria	☐	☐	
blood in urine (hematuria)	☐	☐	
urinary frequency	☐	☐	
urinary urgency	☐	☐	
loss of bladder control	☐	☐	

	YES	NO	
Musculoskeletal:			
back pain	☐	☐	
joint pain	☐	☐	
muscle weakness	☐	☐	
leg pain	☐	☐	
arthritis	☐	☐	
Endo:			
diabetes	☐	☐	
thyroid disease	☐	☐	
Psych:			
nervousness	☐	☐	
anxiety	☐	☐	
mood swings	☐	☐	
depression	☐	☐	
Heme:			
anemia	☐	☐	
Immunological:			
HIV/AIDS	☐	☐	
Leukemia	☐	☐	
Neuro:			
seizures	☐	☐	
tremors	☐	☐	
syncope	☐	☐	
memory Loss	☐	☐	
loss of balance	☐	☐	
headache	☐	☐	
blurred vision	☐	☐	

_____ _____
Patient Signature Date/Time

_____ _____
Nurse Signature Date/Time