ORTHO SPINE AMERICA

Initial Visit Questionnaire

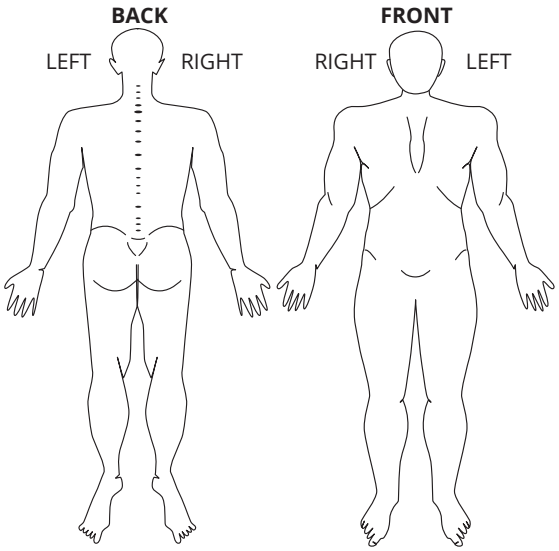
NAME _____ DOB _____ DATE _____

Ht _____ Wt _____ BP _____

1. Please circle the reason for your visit today:

PAIN **WEAKNESS** **NUMBNESS** **STIFFNESS** **SWELLING**

2. Where are your symptoms located? (Please mark "X" for pain and "O" for numbness/tingling)



3. When did your symptoms start? _____

4. Did you have an injury or a fall? _____ If yes, is the injury work related? _____

5. Are your symptoms a result of an automobile accident? _____

6. What is your current pain level? **(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)**

7. Describe your pain: ☐ **ACHING** ☐ **BURNING** ☐ **DULL** ☐ **SHARP** ☐ **STABBING** ☐ **THROBBING**

8. Are your normal daily activities restricted due to your current symptoms? _____

9. What exacerbates your pain? _____

10. What relieves your pain? _____

11. Have you had treatment for this problem prior to today's visit? _____

☐ **ER** ☐ **PHYSICIAN** ☐ **INJECTION** ☐ **PT** ☐ **SURGERY** ☐ **OTHER** _____

12. Were the treatments helpful? _____

13. Are you currently taking any medications for this problem? Please list: _____

14. Have you had any diagnostic studies including X-rays, MRI, CT scans or nerve conduction studies?

_____ Where? _____

15. Are you being treated for any chronic medical conditions? _____

16. Are you currently taking blood thinning medications? _____

17. What is your present work status? _____

18. What is your preferred pharmacy? _____