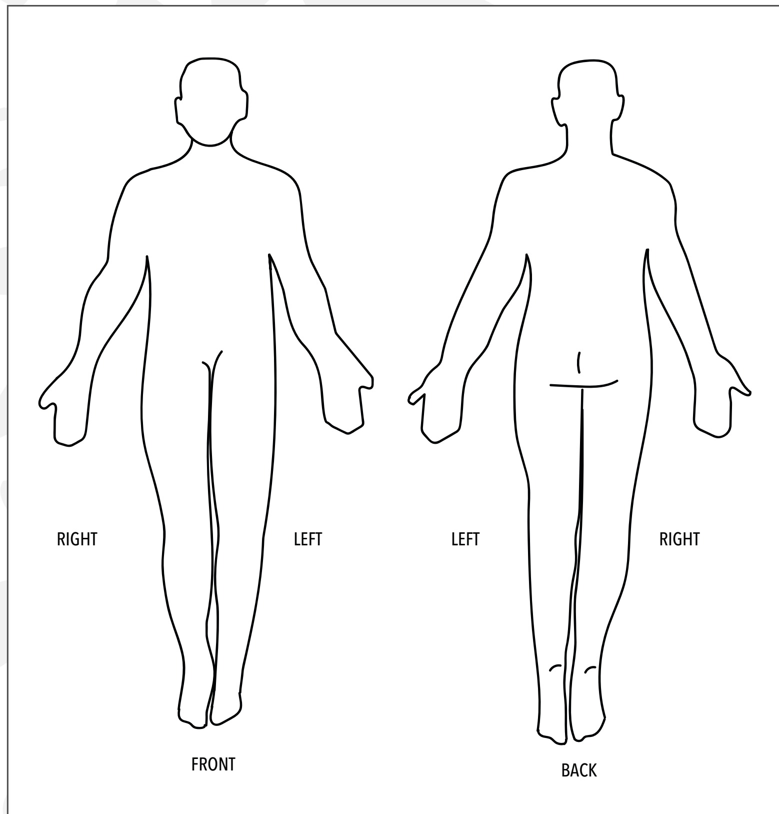
SPINE QUESTIONNAIRE

BAY STREET
ORTHOPAEDICS & SPINE

Patient Name ______________________________

Date of Birth ______________________________

Please mark the area where you experience the following sensations using the symbols to the left.



Ache	^^^^
Numbness	0000
Pins & Needles	====
Burning	XXXX
Stabbing	/////

How bad is your pain? Place an "X" on each of the lines below to indicate your current pain.

How bad is your low back pain?

No Pain **0** _ **10** Worst Possible

How bad is your leg pain?

No Pain **0** _ **10** Worst Possible

How bad is your middle back pain?

No Pain **0** _ **10** Worst Possible

How bad is your neck pain?

No Pain **0** _ **10** Worst Possible

How bad is your arm pain?

No Pain **0** _ **10** Worst Possible

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How does each of the following affect your pain?

Sitting	☐ Better	☐ Worse	☐ No Change	
Standing	☐ Better	☐ Worse	☐ No Change	
Walking	☐ Better	☐ Worse	☐ No Change	
Lying Down	☐ Better	☐ Worse	☐ No Change	
Rising from Chair	☐ Better	☐ Worse	☐ No Change	
Physical Activity	☐ Better	☐ Worse	☐ No Change	
Heat	☐ Better	☐ Worse	☐ No Change	☐ Don't Know
Cold	☐ Better	☐ Worse	☐ No Change	☐ Don't Know
Massage	☐ Better	☐ Worse	☐ No Change	☐ Don't Know

We need to know about the treatments you have already received for your current back/neck pain.

If you have had the following, did it make your condition better or worse?

Chiropractic Care	☐ Better	☐ Worse
Physical Therapy	☐ Better	☐ Worse
Injections	☐ Better	☐ Worse
Psychological Consultation	☐ Better	☐ Worse
Other ____________	☐ Better	☐ Worse

Have you ever had surgery on your back or neck?

☐ Yes ☐ No

If YES, complete the following:

Type of Surgery ____________________
Date ____________________
Surgeon ____________________
Did it make your pain ☐ Better ☐ Worse

Type of Surgery ____________________
Date ____________________
Surgeon ____________________
Did it make your pain ☐ Better ☐ Worse

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Date ____________________
Surgeon ____________________
Did it make your pain ☐ Better ☐ Worse

Bladder Control (urine)

☐ No Problem ☐ Can't Empty Bladder ☐ Loss of Urine (accidents)

Bowel Control

☐ No Problem ☐ Constipation ☐ Loss of Control (accidents)

Do you have any of the following problems?

Is your pain worse at night?	☐ Yes	☐ No
Does your pain awaken you from sleep?	☐ Yes	☐ No
Does coughing affect your pain?	☐ Yes	☐ No
Does your legs tire/hurt if you walk too far?	☐ Yes	☐ No

If YES, how far can you walk?

☐ Less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks

Is this relieved by resting your legs?	☐ Yes	☐ No
Is this relieved by bending forward?	☐ Yes	☐ No