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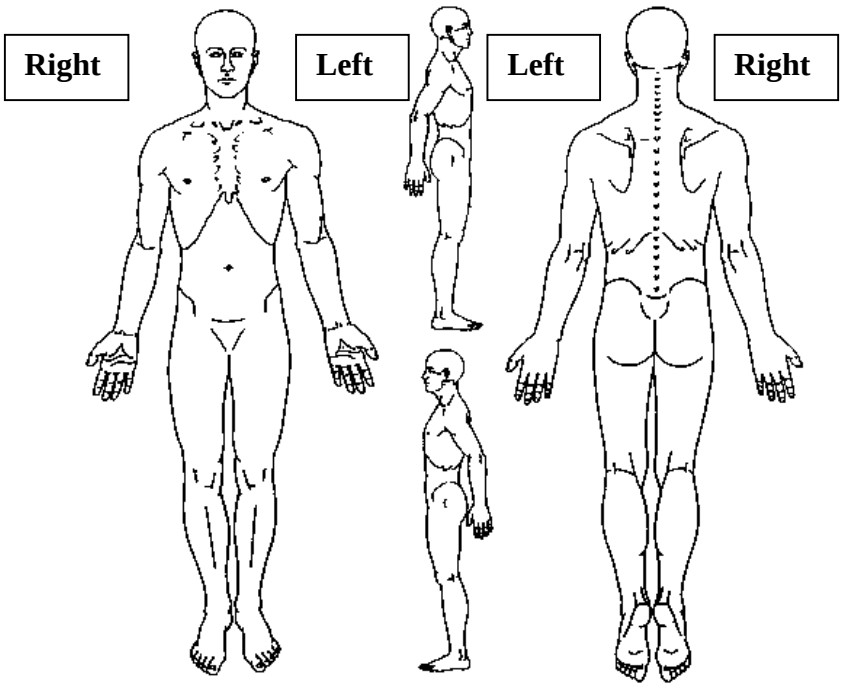
**Lowcountry Spine & Sport**
**New Patient Pain Questionnaire**

The following questions are designed to provide your physician with a thorough understanding of your pain and symptoms. If you do not understand or cannot complete any portion of this form please ask for assistance.

Name: _____ Date_____

**Please mark the figure with the location of your pain/symptoms:**




**Pain = X**

**Numbness/Tingling = #**

**How long have you been having the problem? _____**

**Would you describe the pain as**: **(please circle all that apply)**
ACHING BURNING CRAMPING DULL SHARP STABBING SHOOTING THROBING
OTHER (describe): _____

**Does your pain interrupt: (please circle all that apply)**
Activity/Exercise Happiness Sleep Work Other: _____

**Mark the following scale to reflect your pain on average:**

LEAST 0----1------2----3----4----5----6----7----8----9----10 MOST

**Mark the following scale to show your pain when it is at its worst:**

LEAST 0----1------2----3----4----5----6----7----8----9----10 MOST

**Describe the timing of your pain: (please circle)**
Continuous Intermittent Worse in the morning Worse in the evening No pattern

**Is your pain associated with: (please circle)**
Bowel dysfunction Bladder incontinence Balance/walking difficulty Weakness
Numbness Tingling Headaches

**If you have any of the following symptoms, please circle:** FEVER CHILLS NIGHTSWEATS

**Please answer the following about your pain: (please circle)**

1. Which of the following **REDUCE** your pain?
   NOTHING BENDING FORWARD BENDING BACKWARD REST/SLEEP LYING DOWN
   SITTING STANDING WALKING CHANGING POSITIONS ICE HEAT

2. Which of the following **INCREASE** your pain?
   EVERTHYTHING BENDING FORWARD BENDING BACKWARD REACHING LYING ON BACK
   LYING ON STOMACH SITTING STANDING WALKING CHANGING POSITIONS ROTATION
   COUGHING SNEEZING BEARING DOWN PHYSICAL ACTIVITY EXERCISE

**If you have had any of the following diagnostic studies, please give the appropriate information:**

| | | | |
|---|---|---|---|
| X-RAYS | Body Part- | Location Performed- | Date Performed- |
| MRI | Body Part- | Location Performed- | Date Performed- |
| CT | Body Part- | Location Performed- | Date Performed- |
| EMG Nerve Study | Body Part- | Location Performed- | Date Performed- |

**If you have been treated with any of the following, please circle:**
MEDICATIONS (Over the counter / Prescription) ORAL STEROIDS PHYSICAL THERAPY CHIROPRACTIC
HOME EXERCISES SPINAL INJECTIONS SPINAL SURGERY OTHER: _____

**Please list any pain medications you have taken <u>for the pain</u> in the past and note if they helped or not:**
_____
_____
_____

## If your pain is due to an accident/injury, please complete the following:

1. Date of accident or injury: ____/____/____.
2. Is your injury due to a motor vehicle accident? YES NO If no please go to #3.
   - If yes were you the driver,front seat passenger, rear passenger, or pedestrian? (please circle)
   - Were you wearing a seatbelt? YES NO
   - Were you hit from the rear, front, driver, or passenger side? (please circle)
   - How fast was your vehicle going?
   - How fast was (were) the other vehicle(s) going?
3. Is your injury work related? YES NO Is your injury due to an accident at work? YES NO.
4. Did you ever see a health care provider for back/neck pain prior to the injury? YES NO.
5. Please describe how the accident or injury occurred: _____
   _____

**WORK STATUS**

Are you currently? ___ Working Full time ___ Working Part time
___ Unemployed ___ Disabled, Temporarily ___ Disabled, Permanently
___ Retired

Have you missed any work because as a result of this injury? YES NO
Do you have any work restrictions? YES NO If yes, please explain:
If you are currently NOT working, how long have you been off work due to your back/neck pain? _____
What is your occupation? _____
Where do you work? _____ For how long? _____

**If you work, please place an X next to any of the following you are required to perform:**

| | | | |
|---|---|---|---|
| Assembly Line Work | Using Hand Tools | Stair Climbing | Typing |
| Repetitive Motion | Standing on Concrete Floors | Walking | Driving |
| Carrying | Heavy Lifting | Stooping | Writing |
| Climbing | Desk Work | Extensive sitting | Pushing |
| Cold Exposure | Overhead Lifting | Telephone Work | Pulling |
| Computer Work | Twisting Motion Using Hands | Hammering | |
| Repetitive Motion w/Fine Motor Skills | | | |