

# SPINE QUESTIONNAIRE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

1. Present back or neck complaint (describe): \_\_\_\_\_

Who referred you to Dr. Schoettle: \_\_\_\_\_

1a. If you are here for a non-work related injury, please describe how you were injured (injuries at work are described at #7 below):

2. When did symptoms first begin: \_\_\_\_\_

3. Mark location of pain (in "X"s), numbness (in "O"s) on diagram at right:

3a. Circle appropriate symptoms you are experiencing:

Bowel or Bladder Problems   Burning Sensation  
Coolness   Numbness   Pain   Tingling   Weakness

3b. Location of Symptoms:

Head	Right	Left	
Neck	Right	Left	Central
Shoulder	Right	Left	
Arm	Right	Left	
Lower Back	Right	Left	Central
Buttocks	Right	Left	
Thigh	Right	Left	
Calf	Right	Left	

FRONT



BACK



4. What activities increase symptoms (circle all that apply):

Bed-rest   Coughing or Sneezing   Prolonged Standing   Sex  
Sitting   Standing   Stooping or Squatting   Walking

5. What activity decreases symptoms (circle all that apply):      Bed-rest      Squatting      Standing      Walking

6. Was this the result of a car accident?    Yes    No    If yes, briefly describe accident: \_\_\_\_\_

Were you (circle one):    driver    passenger    pedestrian    Were you wearing a seat belt?    Yes    No

What was the estimated damage to the vehicle?    \$ \_\_\_\_\_

7. Are your symptoms work-related?    Yes    No

Were you injured at work?    Yes    No    Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

First day off work: \_\_\_\_/\_\_\_\_/\_\_\_\_    Last day worked: \_\_\_\_/\_\_\_\_/\_\_\_\_

Briefly describe your injury: \_\_\_\_\_

Briefly describe your normal job requirements \_\_\_\_\_

Any previous work injuries? (please describe) \_\_\_\_\_

8. Describe any previous neck or back injuries or symptoms: \_\_\_\_\_

9. Are you involved in a lawsuit or a potential lawsuit regarding your accident?    Yes    No

If yes, Name of attorney: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

10. List any previous neck or back surgeries: (include year, doctor, location of surgery, hospital)

\_\_\_\_\_  
\_\_\_\_\_

10a. List other medical conditions and any previous surgeries not involving your neck or back (include approximate dates):

\_\_\_\_\_  
\_\_\_\_\_

11. What tests have you had for the current problem (circle all that apply):    CAT-SCAN    EMG    MRI    Myelogram    X-rays  
Please list date and location of tests: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

12. List any medications prescribed for your current problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

13. List all other medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

14. List all allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. Do you smoke?            Yes        No        If yes, Number of years: \_\_\_\_\_    Packs per day: \_\_\_\_\_

16. Any history of drug or alcohol addiction?    Yes        No        If yes, what drugs? \_\_\_\_\_

**REMAINDER OF FORM TO BE COMPLETED BY DR. SCHOETTLE**

17. Physical Exam:            Weight: \_\_\_\_\_    Height: \_\_\_\_\_

General: \_\_\_\_\_

Posture and R.O.M.: \_\_\_\_\_

Muscle spasm or guarding: \_\_\_\_\_

Neck motion / Foramen closing test: \_\_\_\_\_

SLR, sciatic and stretch: \_\_\_\_\_

Motor: \_\_\_\_\_

Sensory: \_\_\_\_\_

DTR's: \_\_\_\_\_

Vascular: \_\_\_\_\_

Other: \_\_\_\_\_

18. Review of outside pertinent x-rays and records: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

19. Diagnosis: \_\_\_\_\_

20. Test to be scheduled: \_\_\_\_\_

21. Medications to be prescribed: \_\_\_\_\_

23. Other Disposition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

24. Work restriction: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

25. Return visit: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_