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Date: _____

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SPINE PATIENT QUESTIONNAIRE

Name: _____ Age: _____ DOB: _____

Chief complaint: _____

Occupation: _____

Are you currently working? [] Yes [] No *When was the last date that you worked? _____

Is this a work-related injury? [] Yes [] No Date of injury _____

Does your problem involve a filed worker's compensation claim? [] Yes [] No

Does your present problem involve a motor vehicle accident? [] Yes [] No Attorney's name: _____

Does your present problem involve a lawsuit? [] Yes [] No Attorney's name: _____

How long have your symptoms been present? _____

How did the problem start? [] Suddenly [] Gradually [] Due to injury/accident

Have you had spine injuries/surgery in the past? [] Yes [] No If yes, when? _____

Are you currently taking any medication for your pain? [] Yes [] No How often: _____

Medication name(s): _____

What makes your pain worse? [] Lifting [] Bending [] Twisting [] Sleeping
(Check all that apply) [] Sitting [] Standing [] Walking [] Running
[] Lying Down [] Coughing [] Sneezing [] Straining [] _____

What makes your pain better? [] Sitting [] Standing [] Lying Down [] _____

How would you rate your pain? [] 1 (very mild) [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 [] 10 (worst ever)

Please list any hobbies which are affected by your condition: _____

Please list your treatment goals and expectations: _____

Do you exercise regularly? [] Yes [] No

Do you smoke? [] Yes [] No If yes, how much per day? _____

Do you drink alcohol? [] Yes [] No If yes, how many beverages/week? _____

Patient Name: _____ Age: _____ Date of Birth: _____

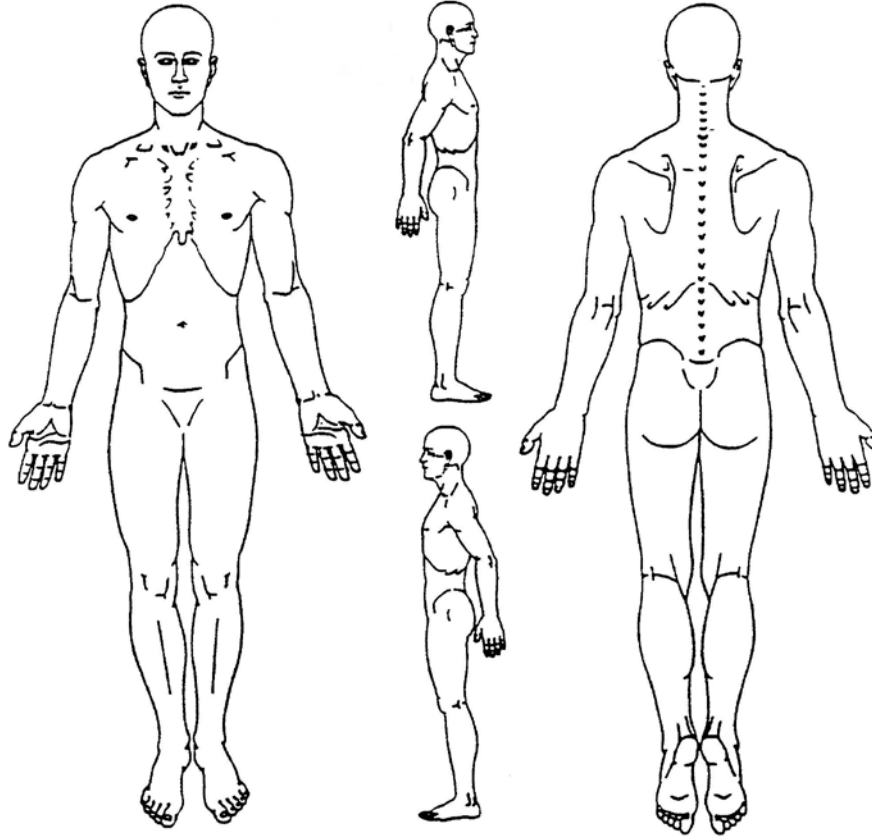
Please use the pain diagram below. Mark the areas on the diagram where you feel the described sensations on your body. Mark areas of radiation. Include all affected areas.

Numbness: (= = =)

Pins and Needles: (0 0 0)

Burning: (XXX)

Stabbing: (///)



Do you have a pain management physician? Yes No

Physician's name: _____

Do you have a signed pain contract? Yes No

Which of the following diagnostic studies have you had for this problem?

X-ray

CT

MRI

Myelogram

EMG

*Have you had any of the following treatments?

Physical Therapy

Facet Injections

Epidural Injections

TENS

SI Joint Injections

Acupuncture

Chiropractic Care

Dry Needling

*If so, *where* did you have the treatments? And how *many*? _____

Patient Signature

Date

Physician Signature

Date

**YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT. THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.
IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.**