Phone - **(262) 395-4141**
Brookfield - 17000 W. North Ave, Ste 104W
Brookfield PT - 2205 N. Calhoun Rd, #17
New Berlin - 12555 W. National Ave, Ste 100
Oak Creek - 8907 S. Howell Ave, #800

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?____________________

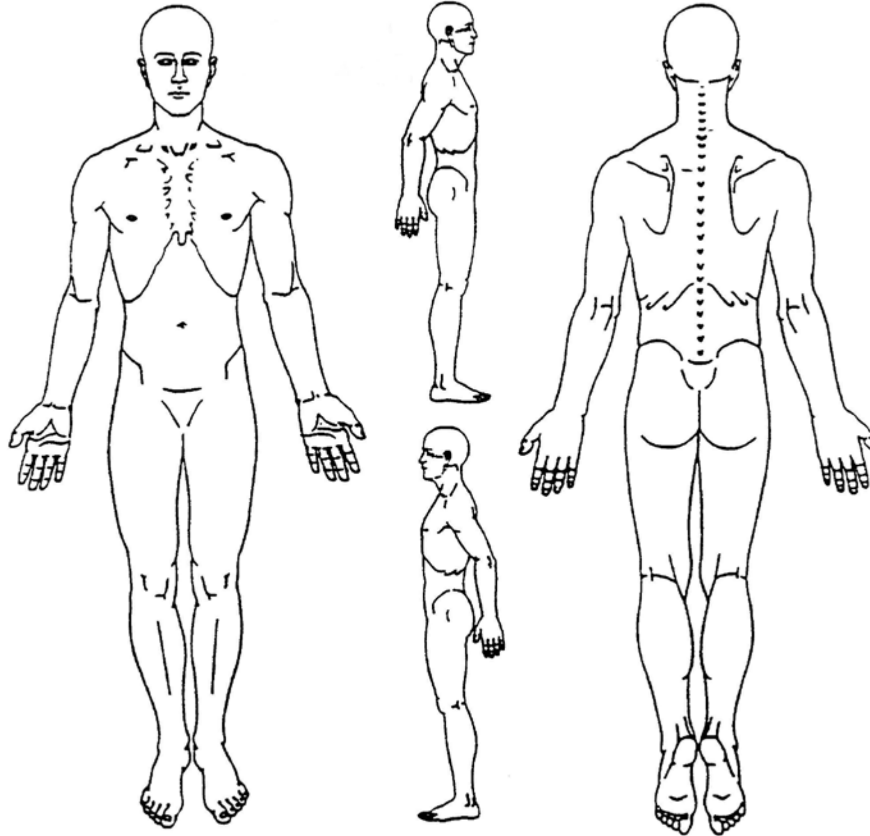
Do you drink alcohol? ☐ Yes ☐ No If yes, how many beverages/week?____________________

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.