

BASELINE QUESTIONNAIRE

Name: _____ Age: _____
Last First Middle Initial

Date: ____/____/200____ Height: ____ft____in Weight: ____lbs

Referring M.D. _____ Primary Treating M.D. (if different) _____

Will you be seeing the referring doctor in follow up? Yes No

1. Are we seeing you for neck (*arm*) pain, mid back or low back (*leg*) pain? _____
(circle one)

2. Who is the primary physician that is treating you for your current spine condition? _____

3. When did you first start having problems with your back / neck? _____
month / day / year

4. Please check all that apply for this injury:

- This is my first episode of back/neck pain. (circle one)
- I have had more than one episode of back/neck pain. In between episodes I don't have much pain.
- I have had pain continuously ever since it first began. Sometimes it is worse than others, but it is always there.
- I have had constant, severe pain ever since it first began.

3. Are your symptoms related to an injury (including repetitive strain injuries)?

- NO
- YES, answer the following:
 - a. The date of the injury was _____(month, day, year)
 - b. The injury was a (*choose one*):
 - Motor Vehicle Injury
 - Lifting Injury
 - Falling Injury
 - Repetitive strain
 - Other
 - c. The injury was (*choose one*):
 - Work related
 - Not work related
 - d. Please describe your injury in as much detail as possible: _____

4. Which of the following types of physicians have you seen for your low back pain?

(Please check all that apply)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Primary Care (including nurse practitioner) | <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Orthopedic surgeon | <input type="checkbox"/> Chiropractor | |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Pain Management | |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Doctor of Osteopath (D.O.) | |

5. Which of the following therapies have you tried for your back or neck pain? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Pain pills (e.g., Tylenol w/ Codeine, Darvocet, etc.) | <input type="checkbox"/> Chiropractic/Osteopathic Manipulations |
| <input type="checkbox"/> Antidepressants (e.g., Elavil, Prozac, etc.) | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Muscle Relaxants (e.g., Flexeril, etc.) | <input type="checkbox"/> Injections, (Trigger Point, epidural, facet, botox, etc.) _____ |
| <input type="checkbox"/> Anti-inflammatories (e.g., Motrin, Advil, Alleve) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Holistic / Herbal | |
| <input type="checkbox"/> Acupuncture | |

6. Have you had surgery for your **current spine injury**?

NO

YES, I have had _____ # of surgeries **relating to my current episode.**

(complete the following relating to your **three most recent** surgeries):

Surgery Number (Most recent first)	Date	Surgery Type / Level (Please provide details.)	Change in condition after Surgery. (circle one)
#1			Same Better Worse for _____ months.
#2			Same Better Worse for _____ months.
#3			Same Better Worse for _____ months.

7. Have you had any of the following diagnostics tests for your current spine pain? (please check all that apply)

	<i>Approx date</i>	<i>Results (If Known)</i>
<input type="checkbox"/> MRI Scan	_____	_____
<input type="checkbox"/> CT Scan	_____	_____
<input type="checkbox"/> Myelogram	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> EMG Test	_____	_____
<input type="checkbox"/> Other	_____	_____

8. What is your understanding of the current treatment plan? _____

9. Have you ever had episodes of pain in other parts of your spine?

NO (IF NO, GO TO QUESTION 10)

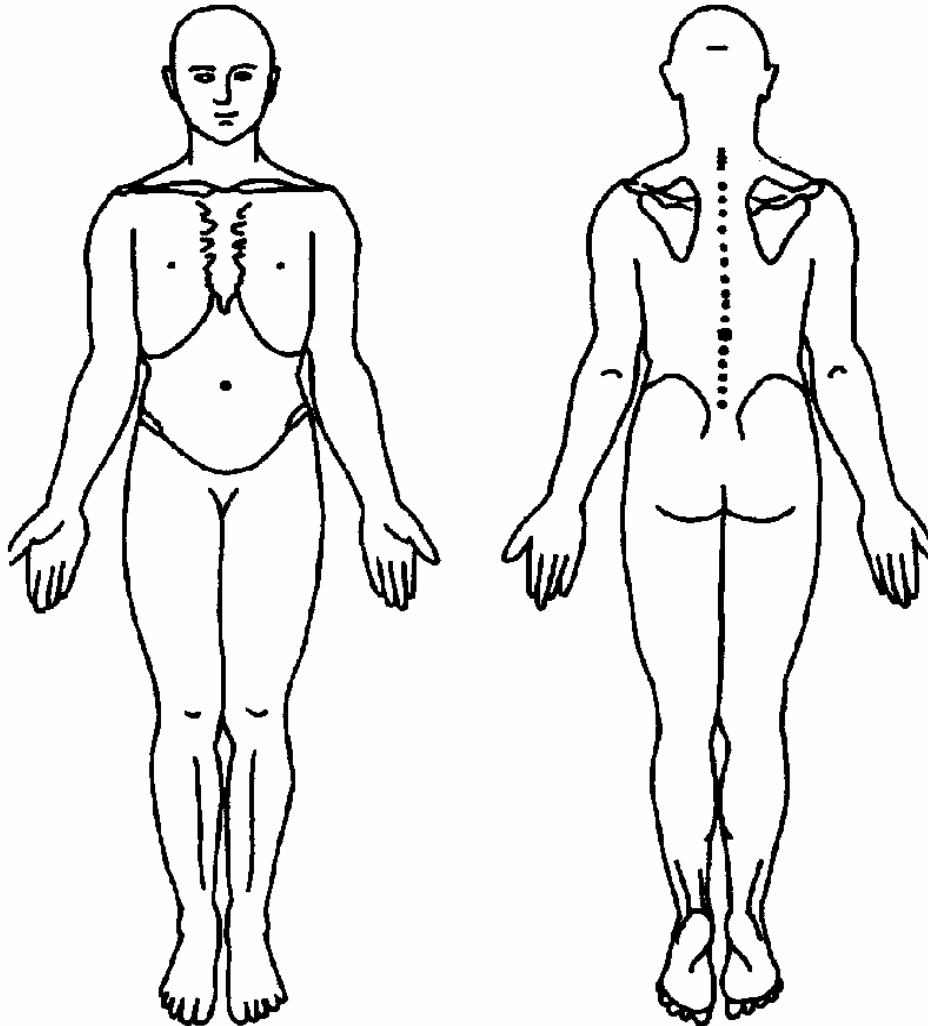
YES How many? _____ (IF YES, answer the questions in the box below then go to question 10)

<p>A. Have you had surgery on other parts of your spine other than what we are treating you for?</p> <p> <input type="radio"/> No, Describe the treatment you received: _____</p> <p> <input type="radio"/> Yes, Type of surgery: _____</p> <p>B. Are you having problems with other parts of your spine other than what we are treating you for?</p> <p> <input type="radio"/> No</p> <p> <input type="radio"/> Yes</p>
--

Questions 10 – 20 relate to your current episode of symptoms

10. Please mark the location(s) of your pain on the body outlines using the symbols below.

OOO Pins & OOO Needles	///// Stabbing /////	XXX Burning XXX
=== Numbness ===	AAAA Aching AAAA & Cramping	+++ Other Sensations +++



Which hurts you more your legs or back?

- legs hurt much more
- legs hurt somewhat more
- legs and back hurt about the same
- back hurts somewhat more
- back hurts much more

OR

Which hurts you more your arm or neck?

- arms hurt much more
- arms hurt somewhat more
- arms and neck hurt about the same
- neck hurts somewhat more
- neck hurts much more

If you have both leg and back pain:

OR

If you have both arm and arm pain

My back is _____% of my pain } should total
 My legs are _____% of my pain } 100%

My neck is _____% of my pain } should total
 My arms are _____% of my pain } 100%

11. Please place a mark on the line at the point that represents your level of pain **TODAY**.

No |-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst Possible Pain
Pain

12. Please place a mark on the line at the point that represents your level of pain **IN THE LAST WEEK**.

No |-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst Possible Pain
Pain

13. Are your symptoms: *(please check one)*

- always there
- sometimes shut off

14. Have your symptoms been:

- improving
- unchanging
- worsening

15. Note the effect of the following activities on your symptoms. *Check one box on each line and fill in the amount of time you can tolerate each activity before changing activity:*

Activity	CHECK ONE	BOX ON	EACH LINE	Tolerance-Time in minutes (fill in each line)
	The Activity has no effect on my symptoms	I Feel Better With...	I Feel Worse With...	
Bending				Not Applicable
Sitting				_____ Min.
Standing				_____ Min.
Walking				_____ Min.
Lying down				_____ Min.
Coughing or Straining				Not Applicable
Reading				_____ Min.
Driving				_____ Min.
Working on Computer/Desk				_____ Min.

16. Pain medication in the last week: *(circle one)*

None	Occasional Non Narcotic	Daily Non Narcotic	Occasional Narcotic	Daily Narcotic
1	2	3	4	5

17. During the past week, how much did pain interfere with your normal work (including both work outside the home and housework)? *(please circle one)*

Not at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

18. If you had to spend the rest of your life with your present pain condition, how would you feel about it? *(please circle one)*

Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied
1	2	3	4	5

19. During the past 4 weeks, about how many days did you cut down on the things you usually do for more than half the day because of your pain? *(please circle one)*

0-5 (days)	6-11 (days)	12-17 (days)	18-23 (days)	24-28 (days)
1	2	3	4	5

20. During the past 4 weeks how many days did your pain keep you from going to work or school? *(please circle one)*

0-5 (days)	6-11 (days)	12-17 (days)	18-23 (days)	24-28 (days)
1	2	3	4	5

21. During the past week, how bothersome have each of the following symptoms been? *(please circle one)*

Circle Back or neck And Leg or Arm	Not at all bothersome	Slightly bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Back pain/ Neck	1	2	3	4	5
Leg pain / Arm	1	2	3	4	5

Staff use only: _____

Questions 22 – 27 relate to your general health

22. Do **you** have a history or have you been told at any time you have/had any of the following:

- Vascular disease (including hardening of the arteries or atherosclerosis, angina, or a history of a heart attack or congestive heart failure)
- Cancer
- History of or prone to Infection
- Rheumatoid arthritis
- Unexplained weight loss
- Fever or chills
- Swollen joints
- Skin disease
- Eye irritation
- Anesthesia Problems
- Fainting Spells
- NONE

23. Have **you** been diagnosed with any of the following conditions? *(Please check all that apply)*

- Heart Disease
- High Blood Pressure
- Bleeding disorders
- Liver Disease
- Kidney Disease
- Diabetes mellitus
- Thyroid
- Ulcer or Gastrointestinal Bleeding
- Neurologic Disease (including stroke, epilepsy, transient ischemic attacks)
- Chronic Lung Disease
- Asthma
- Bronchitis
- Emphysema
- Migraines
- Prior Anesthetic Problems
- Other: _____
- NONE

24. List **ALL prescribed AND over the counter medications** or herbs you are currently taking and daily amount:

_____	_____
_____	_____
_____	_____
_____	_____

25. Please list any allergies you have to medications, including allergies to antibiotics, local anesthetics, x-ray contrast “dye”, or latex materials:

26. Please list any surgery you have had which is not related to your current symptoms including but not limited to transplants, implants, stents, pacemaker, hardware, prosthesis, shoulder, knee, elbow, hand repair, etc.:

_____	_____	_____
_____	_____	_____

27. Have you had any of the following since your current symptoms started? *(check all that apply)*

- episodes of sadness
- depression
- anxiety
- crying spells
- difficulty sleeping
- fever or chills
- unexplained weight loss
- swollen joints
- skin disease
- eye irritation

Questions 28 –43 relate to your employment status and living situation

28. If any of the following describe you, please check and then proceed to question 31

(check one)

- Full-time Homemaker
- Full-time Student
- Retired (Not due to health)
- Permanently disabled due to a health problem no related to my symptoms
- None of the above

29. What is your primary occupation? If you are not working now, indicate your primary occupation when you were working. (Please be as specific as possible)

Occupation: _____

Current Employer: _____

30. Are you currently working?

YES (choose the **ONE** answer that best describes your current work situation)

- I have the exact same job since I started having symptoms
- I have the same job, but it was modified or the hours were reduced because of my symptoms
- I have changed jobs because of my symptoms
- I have changed jobs, but for reasons unrelated to my symptoms

NO (answer the following)

- a. I have been off work for _____year(s)_____month(s)_____week(s)
- b. Check which of the following describes your current work status (please check one)
 - I am unable to work because of my symptoms
 - I am able to work but I am unemployed
- c. Which of the following best describes your plans for future employment (check one)?
 - I intend to return to my same job
 - I plan to return to my occupation but with restricted duty
 - I plan to find a different occupation
 - I don't intend to return to work

31. Have you ever had to miss work because of your **back pain** in the past?

NO

YES. (answer the following)

- | |
|---|
| A. How much work did you miss as a result of your worst prior episode ? _____ |
| B. Did you return to full function before your current episode ? <input type="checkbox"/> Yes <input type="checkbox"/> No |

32. Have you ever had to miss work because of **neck pain** in the past ?

NO

YES. (answer the following)

- | |
|--|
| A. How much work did you miss as a result of your worst prior episode? _____ |
| B. Did you return to full function before your current episode? <input type="checkbox"/> Yes <input type="checkbox"/> No |

33. Have you ever had to miss work because of other medical conditions in the past?

NO

YES, Describe: _____

34. Have you been told your condition is permanent and stationary (workers comp)?
 NO
 YES
35. Have you been given a disability rating?
 NO
 YES, what percent? _____%
36. What is your current living situation?
 Married
 Single
 Divorced
 Living with a partner
37. Are you experiencing financial difficulties because of your symptoms?
 None at all
 Only a little
 Some
 A lot
38. Are you now or have you ever been a regular smoker?
 No
 Yes, I used to smoke regularly but quit _____ years ago.
 Yes, I am currently smoking _____ packs per day / _____ cigarettes per day
39. How many drinks (beer, wine, and liquor) do you have per week?
 Less than one drink per week
 Greater than one drink per week. Average number/week is _____.
 I do not drink alcoholic beverages.
40. Have you ever been told you are alcoholic or chemically dependent or been treated for alcohol or chemical dependency?
 NO
 YES
41. Source of **primary** health care coverage **for this injury** (please check one).
 Private Insurance
 Medicare
 Medicaid
 HMO or PPO
 Self-Pay
 Automobile Insurance
 Workers Compensation
42. Do you think the fault of your current symptoms are (please check the one best answer)
 Yours
 Your employer's
 A co-worker's
 Another person's
 Nobody's
43. Have you hired a lawyer because of your symptoms?
 No, I have not hired a lawyer.
 Yes, I have and the case is in litigation.
 Yes, I have and the case has been settled.