

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

Appointment with:

Dr. Heilman    Dr. Kozak    Dr. Williamson   Appointment Date: \_\_\_/\_\_\_/\_\_\_

## INJURY QUESTIONNAIRE

Why did you make an appointment to see the doctor?

- Evaluation
- Surgical opinion
- Reassurance
- Other

Specify: \_\_\_\_\_

What was the date of your current spinal injury? \_\_\_\_\_

Did you have any non-spinal injuries with your current spinal injury?

- Yes                       No

How were you hurt?

- Assault
- Motor vehicle accident
- Fall
- Lifting
- Running
- Twisting
- Other

Specify: \_\_\_\_\_

What part of your spine/back hurts?

- Cervical                      (neck)
- Thoracic                      (upper back)
- Thoracolumbar              (mid back region)
- Lumbar                      (low back)
- Sacroiliac                    (tailbone)

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**INJURY QUESTIONNAIRE**

Page Two

Please explain how your current injury occurred:

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Did you have any spinal discomfort/symptoms **before** your current injury? If yes, please specify length of time.

Yes       No

	_____	_____	_____	_____
	Numbness/Pain/Weakness			Length of Time
_____ Neck symptoms	_____	_____	_____	_____
_____ Symptoms in both arms	_____	_____	_____	_____
_____ Right arm symptoms	_____	_____	_____	_____
_____ Left arm symptoms	_____	_____	_____	_____
_____ Headaches	_____	_____	_____	_____
_____ Visual changes	_____	_____	_____	_____
_____ Loss of consciousness	_____	_____	_____	_____
_____ Chest symptoms	_____	_____	_____	_____
_____ Thoracic symptoms	_____	_____	_____	_____
_____ Low back symptoms	_____	_____	_____	_____
_____ Symptoms in both buttocks	_____	_____	_____	_____
_____ Right buttock symptoms	_____	_____	_____	_____
_____ Left buttock symptoms	_____	_____	_____	_____
_____ Symptoms in both legs	_____	_____	_____	_____
_____ Right leg symptoms	_____	_____	_____	_____
_____ Left leg symptoms	_____	_____	_____	_____
_____ Other	_____	_____	_____	_____
Specify: _____	_____			

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**INJURY QUESTIONNAIRE**

Page Three

What are your spinal complaints since your current injury? Please specify length of time.

	Numbness/Pain/Weakness	Length of Time
____ Neck symptoms		_____
____ Symptoms in both arms	_____	_____
____ Right arm symptoms	_____	_____
____ Left arm symptoms	_____	_____
____ Headaches		_____
____ Visual changes		_____
____ Loss of consciousness		_____
____ Chest symptoms		_____
____ Thoracic symptoms		_____
____ Low back symptoms		_____
____ Symptoms in both buttocks	_____	_____
____ Right buttock symptoms	_____	_____
____ Left buttock symptoms	_____	_____
____ Symptoms in both legs	_____	_____
____ Right leg symptoms	_____	_____
____ Left leg symptoms	_____	_____
____ Other		_____
Specify: _____		

Did the pain develop  immediately or was the pain  delayed? If delayed, please specify length of time. \_\_\_\_\_

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# INJURY QUESTIONNAIRE

Page Four

NECK TO ARM PAIN RATIO: (Complete only if you have neck pain.)

	Yes	No
Is neck pain greater than arm pain?	<input type="checkbox"/>	<input type="checkbox"/>
Is arm pain greater than neck pain?	<input type="checkbox"/>	<input type="checkbox"/>

Please circle one of the ratios listed below which **best** describes the amount of pain you feel in your neck as compared to your arm.

Neck Pain Compared to Arm Pain:

- 100% neck pain compared to 0% arm pain
- 90% neck pain compared to 10% arm pain
- 80% neck pain compared to 20% arm pain
- 70% neck pain compared to 30% arm pain
- 60% neck pain compared to 40% arm pain
- 50% neck pain compared to 50% arm pain
- 40% neck pain compared to 60% arm pain
- 30% neck pain compared to 70% arm pain
- 20% neck pain compared to 80% arm pain
- 10% neck pain compared to 90% arm pain
- 0% neck pain compared to 100% arm pain

BACK TO LEG PAIN RATIO: (Complete only if you have low back pain.)

	Yes	No
Is back pain greater than leg pain?	<input type="checkbox"/>	<input type="checkbox"/>
Is leg pain greater than back pain?	<input type="checkbox"/>	<input type="checkbox"/>

Please circle one of the ratios listed below which **best** describes the amount of pain you feel in your back as compared to your leg.

Back Pain Compared to Leg Pain:

- 100% back pain to 0% leg pain
- 90% back pain to 10% leg pain
- 80% back pain to 20% leg pain
- 70% back pain to 30% leg pain
- 60% back pain to 40% leg pain
- 50% back pain to 50% leg pain
- 40% back pain to 60% leg pain
- 30% back pain to 70% leg pain
- 20% back pain to 80% leg pain
- 10% back pain to 90% leg pain
- 0% back pain to 100% leg pain

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**INJURY QUESTIONNAIRE**

Page Five

Which health professionals have you seen for your current injury? Please list their names, whether or not they were seen within 24 hours of the injury, and the treatment and medications prescribed.

\_\_\_ Company doctor \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Chiropractor \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Emergency room doctor \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Family doctor \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Internist \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Neurosurgeon \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Neurologist \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Orthopedist \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_  
Treatment/Results \_\_\_\_\_

Medicines/Results \_\_\_\_\_

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**INJURY QUESTIONNAIRE**

Page Six

Please list any medications you are taking for your current injury.

Medication	Prescribed By	Date Initiated	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which treatments have you received for your current injury? Please specify length of time and results.

	Length of time	Results
_____ Acupressure	_____	_____
_____ Acupuncture	_____	_____
_____ Biofeedback	_____	_____
_____ Brace	_____	_____
_____ Chiropractor	_____	_____
_____ Hypnosis	_____	_____
_____ Occupational therapy	_____	_____
_____ Physical therapy	_____	_____
_____ Other	_____	_____
_____ Specify _____	_____	_____

Please list any X-rays/tests performed for your current injury.

X-ray/Test	Area of body	Date	Facility/Hospital	City/State
_____ Bone scan	_____	_____	_____	_____
_____ CT scan	_____	_____	_____	_____
_____ Discography	_____	_____	_____	_____
_____ Doppler studies	_____	_____	_____	_____
_____ EMG/NCV	_____	_____	_____	_____
_____ Facet block injection	_____	_____	_____	_____
_____ Gallium scan	_____	_____	_____	_____
_____ Indium scan	_____	_____	_____	_____
_____ MRI	_____	_____	_____	_____
_____ Myelogram	_____	_____	_____	_____
_____ Nerve root injection	_____	_____	_____	_____
_____ Plain X-rays	_____	_____	_____	_____
_____ Other	_____	_____	_____	_____

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# INJURY QUESTIONNAIRE

Page Seven

With these activities, is your pain better, worse, or unchanged?

	Better	Worse	Unchanged
___ With cough or sneeze	___	___	___
___ Sitting down at a table	___	___	___
___ Sitting in an automobile	___	___	___
___ Bending forward to brush teeth	___	___	___
___ Walking a short distance	___	___	___
___ Lying flat on back	___	___	___
___ Lying flat on stomach	___	___	___
___ Lying on side with knees bent	___	___	___
___ Upon awakening in the morning	___	___	___
___ Mid-morning	___	___	___
___ Middle of the night	___	___	___

PLEASE RESPOND TO THE FOLLOWING QUESTIONNAIRE ABOUT YOUR ABILITY TO FUNCTION. CIRCLE THE **BEST** ANSWER.

## PAIN INTENSITY

1. Tolerate pain without pain medication
2. Pain, but do not take pain killers
3. Pain killers give complete relief
4. Pain killers give moderate relief
5. Pain killers give very little relief
6. Pain killers have no effect on pain, therefore, do not use

## PERSONAL CARE

1. Look after myself normally without causing extra pain
2. Look after myself with some extra pain
3. Painful, but I do it slowly and carefully
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of my care
6. I do not get dressed and stay in bed

## LIFTING

1. I can lift any weight without problem
2. I lift, but it causes spinal pain
3. I cannot lift over 20 lbs
4. I cannot lift over 10 lbs
5. I cannot lift without pain

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## INJURY QUESTIONNAIRE

Page Eight

### WALKING

1. Pain does not prevent me from walking any distance
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than ¼ mile
5. Can only walk using a cane or crutch
6. Restricted to bed and have to crawl to the toilet

### SITTING

1. Can sit in any chair as long as I like
2. Can only sit in my favorite chair as long as I like
3. Cannot sit more than 1 hour
4. Cannot sit more than ½ hour
5. Cannot sit more than 10 minutes
6. Cannot sit at all

### WORKING

1. Work 8 hours per day without pain
2. Work 8 hours, but it causes pain
3. Cannot work 8 hours, but can work 4 hours
4. Cannot work 4 hours without pain
5. Cannot work

### SLEEPING

1. Pain does not prevent me from sleeping
2. Sleep only with medication
3. Sleep less than 6 hours with medication
4. Sleep less than 4 hours with medication
5. Sleep less than 2 hours with medication
6. Pain prevents me from sleeping at all

### SEX LIFE

1. Normal and causes no extra pain
2. Normal, but causes some extra pain
3. Nearly normal, but is very painful
4. Severely restricted by pain
5. Nearly absent because of pain
6. Pain prevents any sex life at all
7. No response

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## **INJURY QUESTIONNAIRE**

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### **SOCIAL LIFE**

1. Normal with no pain
2. Normal, but increases the pain
3. Limits my more energetic interests, such as dancing
4. Limits my social life; I do not go out often
5. Has restricted my social life to my home
6. No social life because of my pain

### **TRAVELING**

1. Can travel anywhere without extra pain
2. Can travel anywhere with some pain
3. Pain is bad but manage journey over 2 hours
4. Pain restricts journeys to less than 1 hour
5. Pain restricts necessary journeys to less than 30 minutes
6. Pain prevents any travel except to doctor/hospital

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Mark the areas on your body where you feel the described sensations.  
 Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness ===

Pins & Needles oooo

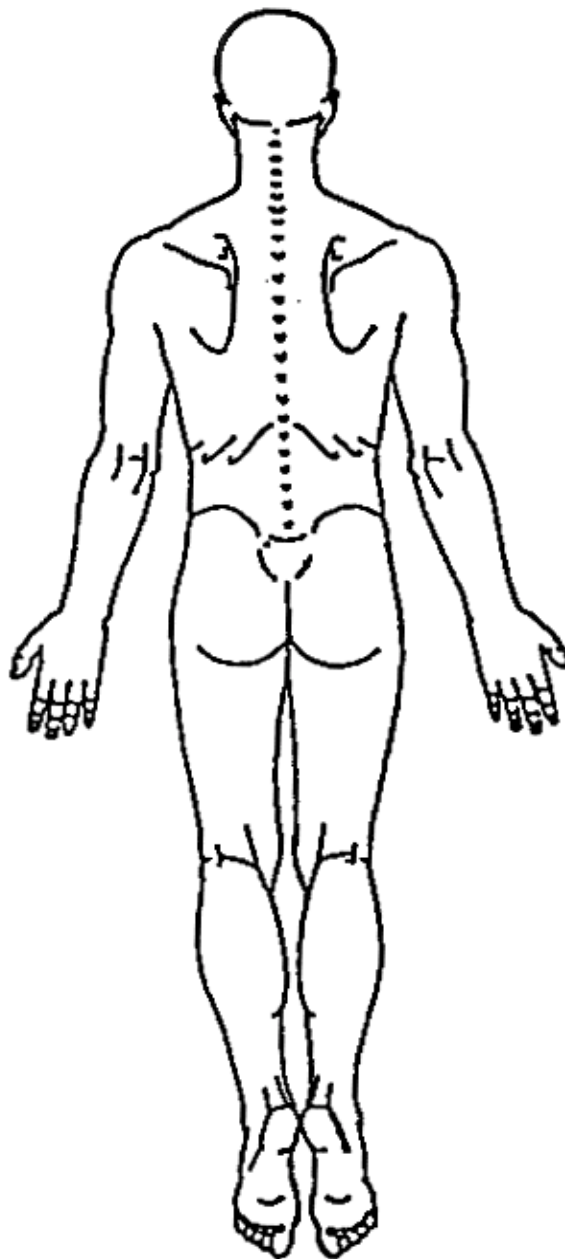
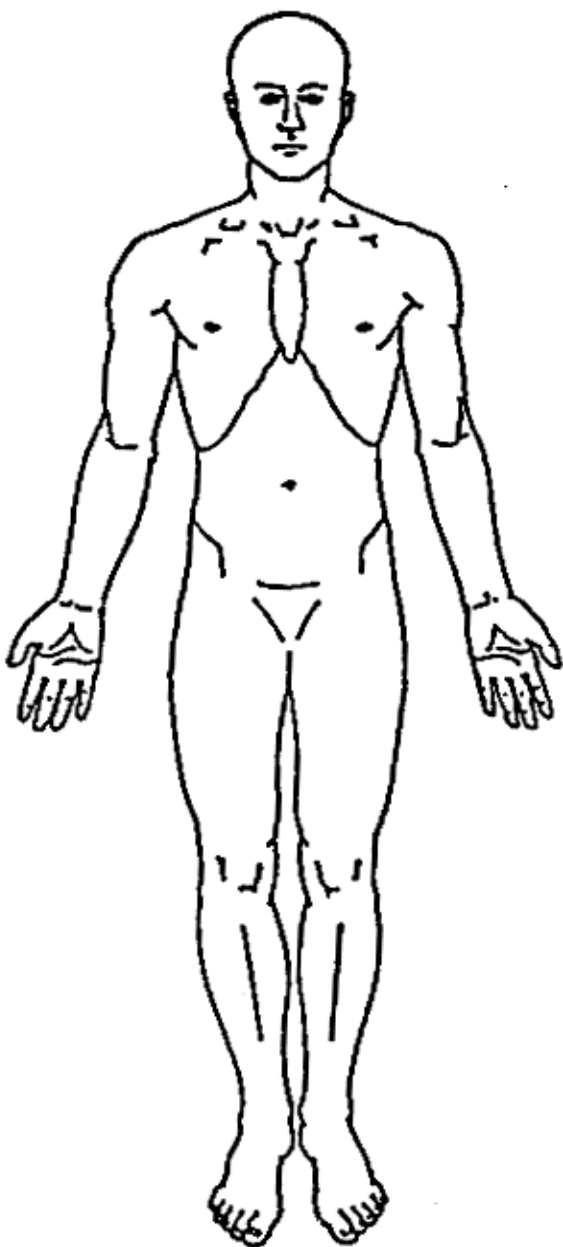
Burning xxxx

Stabbing ///

Chronic Ache zzzz

FRONT  
 RIGHT LEFT

BACK  
 LEFT RIGHT



**ESTIMATE THE SEVERITY OF YOUR PAIN (CHOOSE ONE NUMBER)**

0 No Pain 1 Mild Pain 2-3 Moderate Pain 4-5 Moderate to Severe Pain 6-7 Severe Pain

8-9 Intensely Severe Pain 10 Most Severe Pain PATIENT PLEASE INITIAL \_\_\_\_\_

