Patient Name: _____ Appointment Date: _____

Appointment with: Dr. Jeffrey A. Kozak

NON-INJURY QUESTIONNAIRE

Why did you make an appointment to see the doctor?

___ Evaluation
___ Surgical Opinion
___ Reassurance
___ Other Specify: _____

What part of your spine hurts?

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

Please give a **BRIEF** history of your symptoms:

_____

_____

What was the date of your current onset of symptoms? _____

Is this the first time you have had these symptoms?
If no, please specify date your symptoms first began

___ Yes ___ No Date: _____

Have you ever had surgery on your **NECK** or **BACK**? ___ Yes ___ No
If yes, please complete the following:

1.) Type of surgery: _____
Date: _____ Surgeon:_____
Did it make your pain ___ better ___ worse ___no change

2.) Type of surgery: _____
Date: _____ Surgeon:_____
Did it make your pain ___ better ___ worse ___no change

NECK TO ARM PAIN RATIO: (Fill out only if you have neck pain)

	Yes	No
Is the neck pain greater than arm pain?	___	___
Is arm pain greater than neck pain?	___	___

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: (Fill out only if you have low back pain)

	Yes	No
Is back pain greater than leg pain?	___	___
Is leg pain greater than back pain?	___	___

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

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

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

Which treatment have you received for your current injury? Please specify length of time & 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
___ Bonescan	_____	_____	_____
___ CT Scan	_____	_____	_____
___ Discography	_____	_____	_____
___ Doppler Studies	_____	_____	_____
___ EMG/NCV	_____	_____	_____
___ Facet Block Inj.	_____	_____	_____
___ Gallium Scan	_____	_____	_____
___ Indium Scan	_____	_____	_____
___ MRI	_____	_____	_____
___ Myelogram	_____	_____	_____
___ Nerve Root Inj.	_____	_____	_____
___ Plain X-rays	_____	_____	_____
___ Other	_____	_____	_____

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 CHECK THE **BEST** ANSWER AS IT RELATES TO YOUR CURRENT FUNCTION

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

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

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. Need some help but manage most of my personal care
____ 5. Need help every day in most aspects of my care
____ 6. Do not get dressed and stay in bed

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

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 and I do not go out often
____ 5. Has restricted my social life to my home
____ 6. I have no social life because of my pain

STANDING
____ 1. Pain does not prevent me from standing
____ 2. Cannot stand longer than 1 hour due to pain
____ 3. Cannot stand longer than 30 minutes due to pain
____ 4. Cannot stand longer than 10 minutes due to pain
____ 5. Can only stand with assistance
____ 6. Cannot stand at all

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 30 minutes
____ 5. Cannot sit more than 10 minutes
____ 6. Cannot sit at all

LIFTING
____ 1. Can lift any weight without problem
____ 2. Can lift, but it causes spinal pain
____ 3. Cannot lift over 20lbs
____ 4. Cannot lift over 10lbs
____ 5. Cannot lift without pain

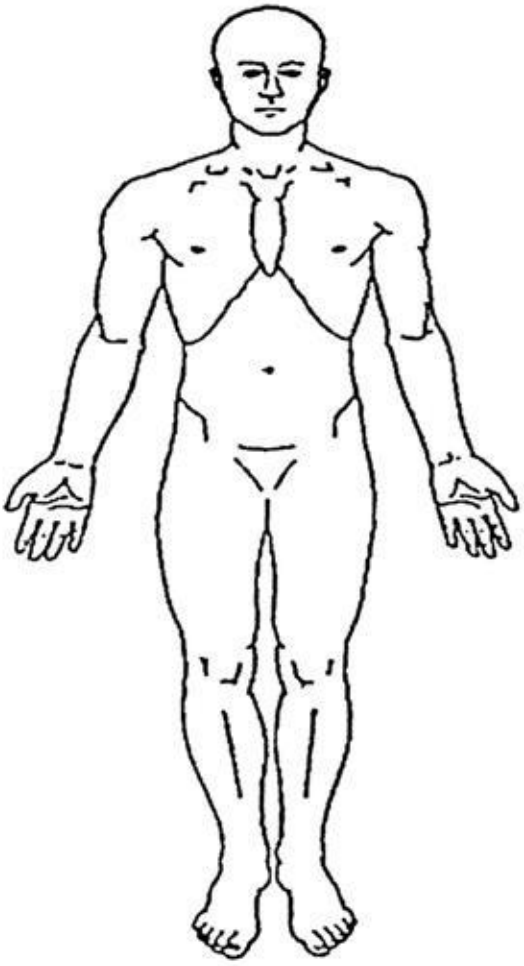
SLEEPING
____ 1. Pain does not prevent me from sleeping
____ 2. Sleep only with medication
____ 3. Sleep less than 6 hours with medication
____ 4. Sleep less than 4 hours with medication
____ 5. Sleep less than 2 hours with medication
____ 6. Pain prevents me from sleeping at all

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 journeys to under 30 minutes
____ 6. Pain prevents any travel except to doctor/hospital

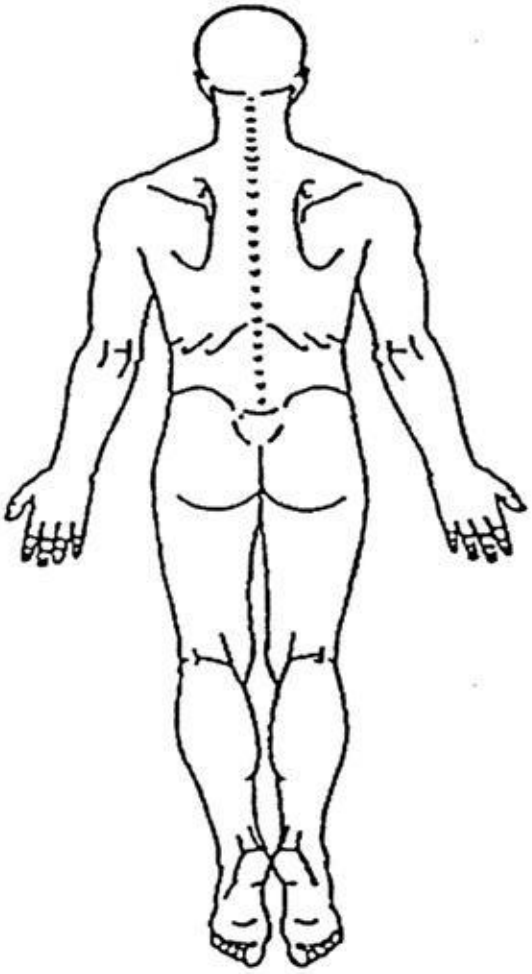
Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

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 _____