PATIENT HISTORY FORM

Name: _____

Date: _____

Height: _____

Weight: _____

Marital status: _____ Number of Children? _____

Occupation: _____ Number of Pregnancies? _____

1 Date of onset of pain? _____

2 What was the cause of your pain?

- ☐ No accident
- ☐ Hit in the back
- ☐ Fall
- ☐ Lifting
- ☐ Auto accident
- ☐ Pulling
- ☐ Twisting
- ☐ Bending
- ☐ Other _____

3 Have you had back/neck pain before the present episode? ☐ Yes ☐ No

4 Have you ever had neck or back surgery? ☐ Yes ☐ No

When and what type?

_____

5 Pain is worse in:

- ☐ Back
- ☐ Neck
- ☐ Buttock or hip
- ☐ Down the arm
- ☐ Down the leg
- ☐ Headaches

6 Do you get numbness or tingling in your legs? ☐ Yes ☐ No

7 Do you get numbness or tingling in your arms? ☐ Yes ☐ No

8 Is your pain getting ☐ Worse ☐ Better ☐ Unchanged

9 Is your pain ☐ Constant ☐ Intermittent

10 What activities make the pain worse?

- ☐ Exercise
- ☐ Bending forward
- ☐ Jarring/Vibration
- ☐ Sitting
- ☐ Bending backward
- ☐ Driving
- ☐ Standing
- ☐ Coughing
- ☐ Sleeping
- ☐ Walking
- ☐ Sneezing
- ☐ Other
- ☐ Lifting
- ☐ Twisting

_____

Please Turn Over

PATIENT HISTORY FORM

11 What reduces your pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Physical therapy
- ☐ Medicine
  - Pain pills ☐
  - Muscle relaxants ☐
  - Anti-inflammatories ☐

12 What treatment have you had?

- ☐ Physiotherapy
- ☐ Chiropractic
- ☐ Corset
- ☐ Bed rest in hospital
- ☐ Traction in hospital
- ☐ Epidural injection
- ☐ Facet injections
- ☐ Acupuncture

13 List past operations (other than spinal surgery):

_____

14 Do you exercise on a regular basis? ☐ Yes ☐ No

How often: _____

15 Do you smoke? ☐ Yes ☐ No ☐ Reformed

16 Please list your current medicines and pain pills:

_____

_____

17 Please rate your general heath: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

18 General medical problems:

- ☐ Stomach problems, ulcers etc
- ☐ Diabetes
- ☐ Arthritis
- ☐ Cancer
- ☐ Heart
- ☐ Gout
- ☐ Epilepsy (Fits)
- ☐ High blood pressure
- ☐ Other

_____

19 Do have bladder or bowel problems? ☐ Yes ☐ No

Have they developed since the onset of your pain? ☐ Yes ☐ No

20 Allergies? ☐ Nil ☐ Yes (list below)

_____

21 Is there a family history of back/neck trouble? ☐ Yes ☐ No

22 Name other specialists you have seen for this condition

_____

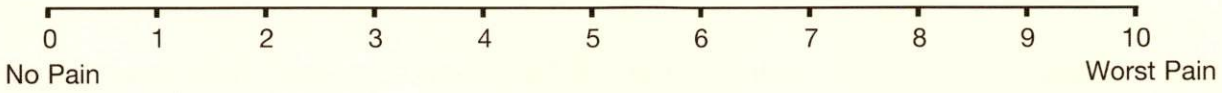
_____

23 Are you involved in litigation or compensation due to your back/neck problem?

☐ Yes ☐ No

PATIENT HISTORY FORM

24 Please indicate by a mark on the line below how much pain you have had in your neck or back on average during the past week.



25 Do you have to rest during the day because of your pain?

- ☐ No
- ☐ A little
- ☐ Half the day
- ☐ Over half the day

26 How often have you seen a doctor or had treatment (eg physiotherapy) for your pain?

- ☐ Never
- ☐ Rarely
- ☐ About once a month
- ☐ More than once a month

27 At present, are you working? (housewives/men relate activity to previous activities)

- ☐ Full time at your usual job
- ☐ Full time at a lighter job
- ☐ Part time
- ☐ Not working

28 At present can you undertake sports or active pursuits? (eg dancing)

- ☐ As much as usual
- ☐ Almost as much as usual
- ☐ Some, much less than usual
- ☐ Not at all

29 At present, can you undertake household chores or odd jobs?

- ☐ Normally
- ☐ As much as usual but slowly
- ☐ Not as many as usual
- ☐ Not at all

30 Mark the box that describes best how much your back/neck pain affects each of the following activities.

	No Effect	Mildly / Not Much	Moderately / Difficult	Severely / Impossible
Sleeping	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Travelling	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Sex life	☐	☐	☐	☐
Working	☐	☐	☐	☐
Sports	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Please Turn Over

PATIENT HISTORY FORM

31 How often do you take pain killers for your pain?

- ☐ Never
- ☐ Occasionally
- ☐ Almost every day
- ☐ Several times each day

32 Choose the Activity Level from the list below that best represents your functional capacity

- ☐ Bedridden
- ☐ Wheelchair
- ☐ Housebound
- ☐ Light physical activity
- ☐ Light duties
- ☐ Restricted medium duties
- ☐ Medium duties
- ☐ Heavy work with pain
- ☐ No limitation

33 CAN YOU

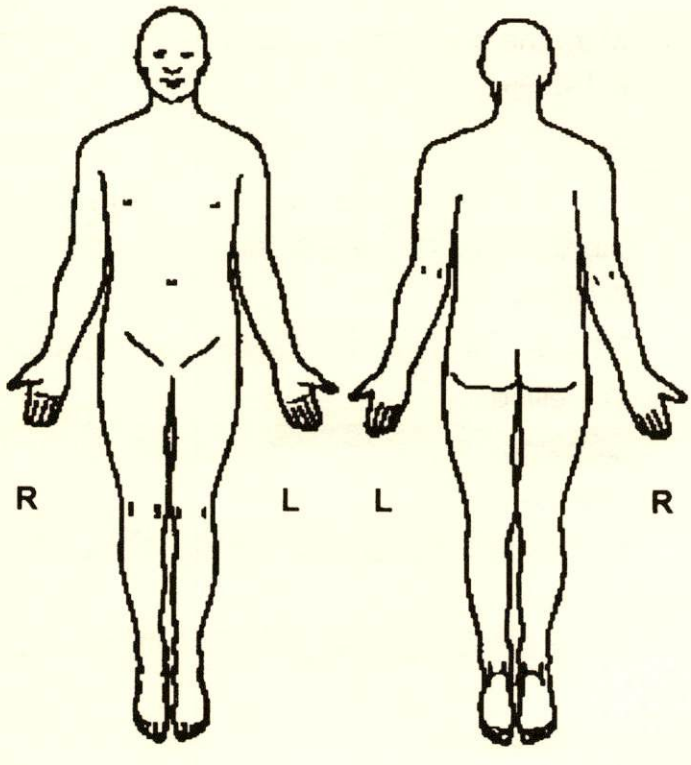
	YES	NO
Lift a small (3 year old) child?	☐	☐
Sit for half an hour?	☐	☐
Stand in one place for half an hour?	☐	☐
Travel in a car or bus for half an hour?	☐	☐
Walk 500 metres?	☐	☐
Put on footwear, tights, socks etc without help?	☐	☐
Vacuum, do washing, shopping, mow lawns and do general home maintenance without help?	☐	☐

DOES YOUR BACK/NECK PAIN

	YES	NO
Disturb your sleep regularly? (2 - 3 times per week)	☐	☐
Curtail your social activities?	☐	☐
Reduce your frequency of sexual activity?	☐	☐

34 Indicate in RED the areas on your body where you feel pain.

Shade in BLUE the areas on your body where you feel numbness, tingling or pins & needles.



35 Would you be prepared to undergo a spinal operation if it is recommended to you by the spinal surgeon?

NO ☐ YES ☐