OrthoNebraska Spine Center Return Patient Questionnaire

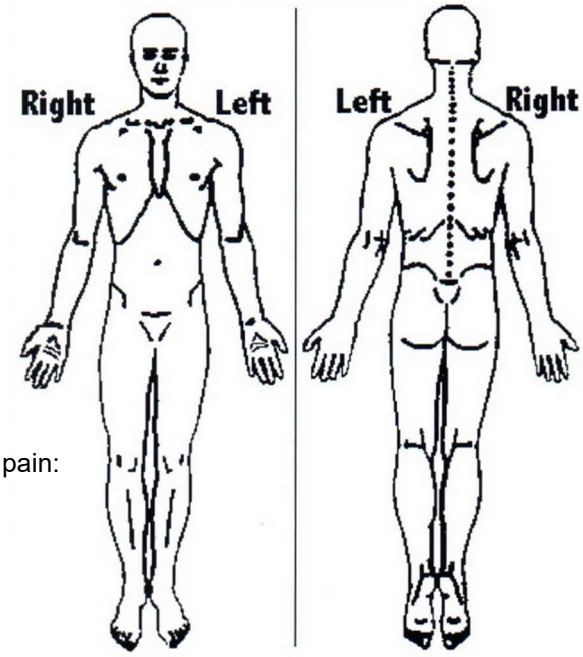
Date: _____

Name: _____

Primary Care Physician: _____

Referring Physician: _____

What is the main reason for today's visit? _____



1. Since your last visit, is your pain:
   Better / Worse / Unchanged

   If you answered better, provide a percentage of improvement: __%

2. On the diagram to the right, please place an "X" where your pain starts.

3. If your pain radiates, draw an arrow on the diagram over the area the pain radiates.

4. Circle the most consistent descriptors below that describe your pain:
   Sharp / Dull / Achy / Burning / Numbness / Tingling / Cramping / Stiff

5. What makes your pain worse:
   Sitting / Standing / Walking / Bending / Lying down / Exercise / Other:_____

6. What is your pain today on a scale of 0-10 (0 meaning no pain; 10 meaning the worst imaginable pain)?
   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

7. What is your pain at its worst on a scale of 0-10?
   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

8. What is your pain at its best on a scale of 0-10?
   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

9. What is your pain on an average day on a scale of 0-10?
   0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

10. Have you experienced:

Fevers:	YES	NO	
Headaches:	YES	NO	
Loss of bowel control:	YES	NO	
Loss of bladder control:	YES	NO	
Rashes:	YES	NO	
Weakness:	YES	NO	If yes, where: _____
Numbness and/or Tingling:	YES	NO	If yes, where: _____
Depressed mood:	YES	NO	
Anxiety:	YES	NO	
Sleep problems:	YES	NO	
Pregnant or breast feeding:	YES	NO	

11. Since our last visit, have there been any changes to your overall medical health: YES NO

If yes, please describe any changes: _____

_____

_____

_____

_____

Thank you very much for your time. This information may be helpful in diagnosing and managing your health care concerns.