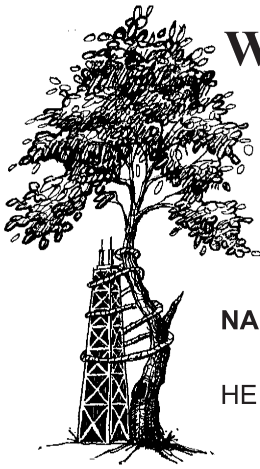


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue   Chicago, Illinois 60659

Toll Free 877-549-4490   Suburban 847-475-0200   Chicago 773-743-1981

TODAY'S DATE ______/______/______

PATIENT INFORMATION QUESTIONNAIRE: SPINE

NAME ____
FIRST   MIDDLE   LAST

HEIGHT ____________   WEIGHT _____________   AGE __________

I AM RIGHT HANDED   I AM LEFT HANDED (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction   Desk Job   Driving   Teacher

Executive/Professional   Factory   Homemaker   Retired   Sales   Student

Other (Please List) ____

IF YOU ARE NOT WORKING NOW, WHEN DID YOU LAST WORK? ______/______/______

DOES IT REQUIRE LIFTING? HOW OFTEN DO YOU LIFT THESE WEIGHTS? (Please Circle)

None   10 lbs. or less   10-50 lbs.   50-100 lbs   More than 100 lbs.

Rarely   Frequently   Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)

Squat   Push   Pull   Lift Overhead   Climb Ladders/Stairs   Reach   Bend   Stoop

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle)   Yes   No

Company Name ______________________________ Company Phone (_______)____________

Company Address ____
STREET   CITY   STATE   ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle)   Yes   No

Lawyer's Name ______________________________ Lawyer's Phone (_______)____________

Lawyer's Address ____
STREET   CITY   STATE   ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)

Right: Shoulder   Elbow   Wrist   Hand   Fingers   Hip   Knee   Ankle   Foot   Toes

Left: Shoulder   Elbow   Wrist   Hand   Fingers   Hip   Knee   Ankle   Foot   Toes

Back   Left Buttock   Right Buttock   Left Groin   Right Groin   Left Thigh   Right Thigh

Other (Please List) ____

____

PLEASE CIRCLE YOUR ONE MAJOR COMPLAINT! PLEASE CHECK (✔) ANY OTHER COMPLAINTS

Aching/Soreness	Limping	Getting Up From a Chair
Popping/Noises	Loss of Activities	Loss of Work
Back or Neck Pain	Leg or Arm Pain	Driving
Reading/Sitting	Sports/Running are Limited	Numbness in the Arms or Legs
Standing	Stiffness	Deformity/Spinal Curvature

Difficulty With: Lifting   Putting on Clothes/Shoes   Stairs   Loss of Motion   Weakness   Walking

Any Other Complaints ____

____

HAVE YOU EVER HAD A NECK OR BACK INJURY OR PAIN? YES   NO   (See Last Page for Surgery)

WHEN?____

____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

________ Days Ago ________ Weeks Ago ________ Months Ago ________ Years Ago

An Injury : On ____/____/____

________ Days Ago ________ Weeks Ago ________ Months Ago ________ Years Ago

I Don't Know When _________________ Gradually Since ____

Other____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR BACK, BUTTOCKS OR HIP? Yes No

How long have you been off work? ____ days ____weeks ____ months ________ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR BACK, BUTTOCKS OR HIP? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling | Hit By Object | Running/Jumping
Hit By Another Player | Slipped on Ice/Water/Oil | Tripping
Noncontact | Pulling/Pushing | Reaching
Twisting | Vehicle Accident | Ankle/Foot was run Over

Other____

____

INJURED DURING:(Please Circle)

Aerobics | Basketball | Baseball
Bicycling | Football | Handball
Racquetball | Running | Soccer
Skiing | Tennis | Volleyball

Other ____

____

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On ____________________________ Time of Day ______ AM PM

Was any equipment, machinery and/or object involved in the accident? **Yes** **No**

If yes,please explain ____

____

Was the accident reported to your supervisor and/ or employer at the time of the injury? **Yes** **No**

IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION

Vehicle Accident On _____/_____/_____ Time of Day ______ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? **Yes** **No**

Did you strike your head or lose consciousness? **Yes** **No**

If you were passenger,what was your position in the vehicle? __________________________________

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other ____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other ____

____

Was your vehicle moving when it was struck? **Yes** **No** How fast was it going? ____________________

Was the accident reported to the police? **Yes** **No**

What was the weather? ____

Did your vehicle strike another vehicle or object? **Yes** **No** Please Describe: ____________________

____

Other ____

____

____

IF YOU ARE EXPERIENCING **PAIN**: PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have ______% Good Days ______ % Bad Days ______ % Average Days

LOCATION OF THE PAIN (Please Circle All those That Apply)

Neck Only	Back Only	Neck and Back
Neck and Arm/Hand	Back and Hip/Leg	Between Shoulder Blades
Anterior Thigh	Posterior Thigh	Lateral Thigh
Arm/Hand Without Neck Pain	Hip/Leg Without Back Pain	Tailbone

THE PAIN GOES TO: (Please Circle All those That Apply)

Back of the Head	Between My Shoulder Blades	Shoulder
Elbow	Back of the Hand	Palm of the Hand
Tailbone	Hip/Buttocks	Groin
Anterior Thigh	Posterior Thigh	Lateral Thigh
Knee	Anterior Shin	Posterior Calf
Top of the Foot	Sole of the Foot	Big Toe

WHERE DID YOUR PAIN START? ______________________________

WHERE DID YOUR PAIN SPREAD?(if anywhere) ______________________________

FREQUENCY OF PAIN: (Please Circle All Those That Apply)

Recent Onset	Occassionally	Irregularly
Unpredictable	Some Days	Most/ Every Day
Constantly	At Work	Most/Every Night
Even When Resting	With or After Activity/Sports	Initially But Not Now
Getting More Frequent	Getting Less Frequent	Frequency is Unchanged

Other ______________________________

TIME OF DAY WHEN THE PAIN OCCURS: (Please Circle The MajorTime of Day and Check (✔) Any OthersThat Apply)

Morning	Late in the Day	Evening
Unpredictable	Irregular	Good & Bad Days
At Work	All Day/Constant	No Apparent Pattern to the Pains
Interrupts My Sleep	Other ______________	

HOW OFTEN DO YOU WAKE UP AT NIGHT OR HAVE DIFFICULTY GOING TO SLEEP?

Never	Rarely/Sometimes	Most Nights
Every Night	I Can Sleep But Only When I Take Medicine	I Can't Sleep Even When I Take Medicine

BECAUSE OF MY NECK OR BACK PAIN I HAVE TO SLEEP : (Please Circle)

I Have No Difficulty Sleeping	On My Back	On My Stomach
On the Affected Side	Sitting Up	Without Sheets Touching My Legs/Feet

THE NECK/BACK PAIN IS:

Sharp/Knifelike	Dull	Aching
Electric Shock	Burning	Continuous
Worst in the Morning	Worst in the Evening	Soreness but not pain

Other ______________________________

DO YOU HAVE PAIN WITH LIFTING:

Telephone Book or 1 Pint of Milk (1-2 lbs.)	Yes	No
Sack of Flour or 1 Gallon of Milk (5-10 lbs.)	Yes	No
A Small Child (25-50 lbs.)	Yes	No
50-100 lbs.	Yes	No
More Than 100 lbs	Yes	No

PAIN RELIEVED BY: (Please Circle All Those That Apply)

Nothing	Rest	Using a Walker/Crutches/a Cane
Activity	Heat	Cold/Ice
Medicine	Cortisone Injection	Moving the Hip
Orthotics/Arch Supports	Wide Shoes	Prescription Shoes
Physical Therapy	Avoiding High heels	Wearing sandals/house slippers

Other ______________________________

PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED

0 1-2 3-4 5-6 7-8 9-10

0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

How bad is your pain today?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the worst its ever been?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the best its ever been?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your lifestyle?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your work?	0	1	2	3	4	5	6	7	8	9	10
Do you have pain lying in bed or at rest?	0	1	2	3	4	5	6	7	8	9	10

WHAT ACTIVITES OR POSITIONS MAKE THE PAIN WORSE?: (Please Circle All Those That Apply)

Nothing Specific	Walking	Standing
Sports	Running/Jumping	Climbing Up/Down Stairs/Ladders
Coughing/Sneezing	Reading	Carrying Things (laundry,groceries etc.)
Lifting/Reaching	Pulling/Pushing	Housework/Yardwork
Squatting/Kneeling	Twisting	Getting Up From a Chair to Walk
Hills/inclines/uneven ground	Weather Changes	Sitting(driving,airplane,theater etc.)
Lying Down	Bending Over	Yardwork/ Housework
Dressing/Putting on Clothes	Putting on Shoes/Socks	Sexual Activity

Other ______________________________________

____

Which sports make the pain worse? (Please List) ______________________

WHAT ACTIVITIES OR POSITIONS MAKE THE PAIN BETTER?: (Please Circle All Those That Apply)

Nothing	Rest	Lifting
Activity/Moving Around	Standing	Pulling/Pushing
Heat	Cold/Ice	Lying Down
Medicine	Sitting	Twisting
A Brace	Physical Therapy	Bending

Other ______________________________________

HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN? YES NO

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Darvocet-N-100(propoxyphene)	Motrin/Ibuprofen/Advil	Daypro(oxaprozin)	Dantrium(dantrolene)
Tylenol #3 (codeine)	Aspirin	Clinoril (sulindac)	Flexeril (cyclobenzaprene)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Skelaxin(metaxalone)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Robaxin(methocabamol)
Tylenol (acetaminophen)	Voltaren(diclofenac)	Relafin(nabumetone)	Neurontin (gabapentin)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Lyrica(pregabalin)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other ______________________________________

Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? ______________________

DOES THE MEDICATION HELP? Yes No Only A Little Bit

NONPAIN SYMPTOMS/COMPLAINTS

MAXIMUM WEIGHT YOU CAN PUSH/PULL: None 25-50 lbs. 100 lbs. More than 100 lbs.

MAXIMUM WEIGHT YOU CAN CARRY: (Please Circle) Weight of the Arm Only

Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

HIP RANGE OF MOTION: (Please Circle All those That Apply)

Normal Can't Lift Hip Up Can't Extend Hip Back

Can't Twist Hip "Out" Can't Twist Hip "In" Can't Touch One Heel to the Other Knee

MOBILITY OF THE HIP: (Please Circle All those That Apply)

Able to Walk Normally Able to Walk With a Limp Able to Run Normally

Unable to Run Unable to Walk Without a Cane, Crutches,Brace or Walker

How Often Do You Limp or Need an Aid to Walk? Daily Once a Week Once a Month

Other ______________________________

MAXIMUM TIME YOU COULD SIT IN ONE PLACE F I PUT A GUN TO YOUR HEAD! (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

MAXIMUM TIME YOU COULD STAND IN ONE PLACE IF I PUT A GUN TO YOUR HEAD! (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

MAXIMUM DISTANCE YOU COULD WALK IF I PUT A GUN TO YOUR HEAD! (Please Circle)

From Bed to Wheelchair Across the Room Less Than 1 Block

1 to 4 Blocks 4 Blocks to 1 Mile ________ Miles/Unlimited

Could you walk as far if you could not use an aid such as a cane or crutches? YES NO

AIDS TO WALKING CURRENTLY IN USE: (Please Circle All those That Apply)

No Aids Necessary Brace Cane Crutches Walker Wheelchair

Could you go as far if you could not use an aid such as a cane or crutches? YES NO

MAXIMUM NUMBER OF STAIRS THAT YOU CAN CLIMB IF I PUT A GUN TO YOUR HEAD! (Please Circle)

None A Few Steps 1/2 Flight 1 Flight 2 or More Flights I Need the Railing

DO YOU HAVE WEAKNESS IN THE ARMS or LEGS? YES NO

Where?______________________________

DO YOU FEEL CRUNCHING, GRINDING, SNAPPING, POPPING, GRATING OR "FUNNY NOISES"? (Please Circle)

Never Noticeable When Walking I Can Feel Them I Can Hear Them

Where?______________________________

ARE THE "NOISES" PAINFUL? YES NO

DO YOU HAVE ANY ABNORMAL SENSATIONS? (Please Circle All Those That Apply)

NONE Numbness Tingling

Pins & Needles Funny Feelings Burning

Where? ______________________________

DO YOU DROP THINGS OR HAVE PROBLEMS WITH CLUMSINESS? YES NO

DO YOU HAVE ANY PROBLEMS CONTROLLING YOUR BOWELS OR BLADDER? YES NO

DO YOU HAVE STIFFNESS IN THE BACK OR NECK? (Please Circle All those That Apply)

None Always After Activity or Sports

When Sitting/Driving In the Morning End of the Day

Other ______________________________

A**CTIVITIES YOU CAN NOT DO BECAUSE OF THE NECK OR BACK PAIN** (Please Circle All those That Apply)

None Pushing Dressing/Putting on Clothes Sitting(driving,airplane,theater etc.)

Lifting Pulling Putting on Shoes/Socks Climbing Up/Down Stairs

Reaching Bending Getting Up From a Chair to Walk Running/Jumping

Reading Standing Yardwork/Housework Sexual Activity

Twisting Walking Squatting /Kneeling Carrying Things (groceries,laundry etc.)

Other ______________________________

I have had to quit some nonsporting recreational activities I enjoy (Please List) ______________________________

____

HAVE YOU EVER HAD AN ARCH SUPPORT OR ORTHOTIC PRESCRIBED FOR YOU? Yes No
Did They Help? Yes No

HAVE YOU EVER BEEN TOLD YOUR LEG LENGTHS WERE UNEQUAL AND YOU NEEDED A HEEL LIFT?
Yes No

WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN? HOW ARE YOU LIMITED? (Please List)

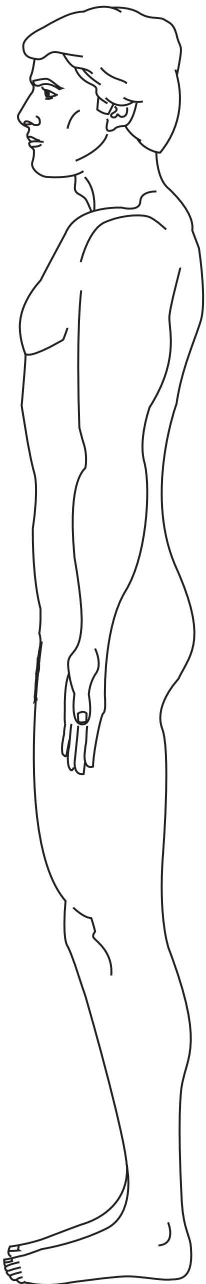
____

HAVE YOU OR DO YOU PARTICIPATE IN COMPETITIVE SPORTS AND AT WHAT LEVEL? (PleaseList)

____

WHERE IS YOUR PAIN? (Please mark on the drawings where you feel the specific type pain or sensation)

Burning XXXX Throbbing ✔✔✔✔ Sharp ////////// Aching ●●●●● Numbness ❋❋❋❋



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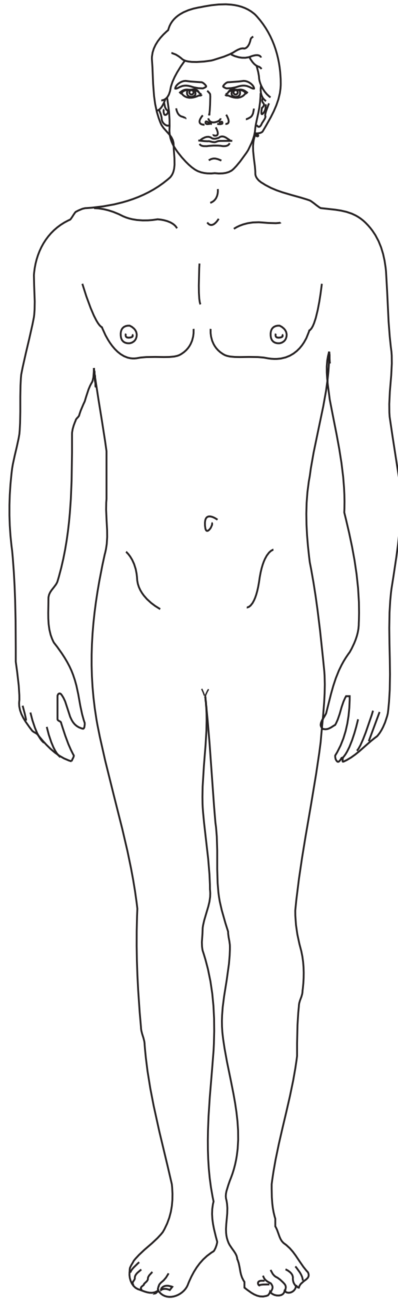

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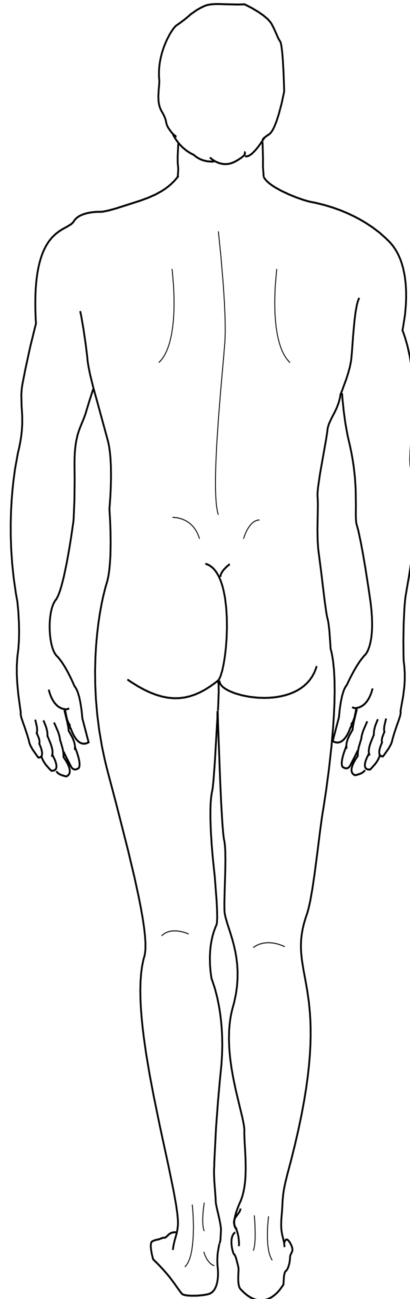

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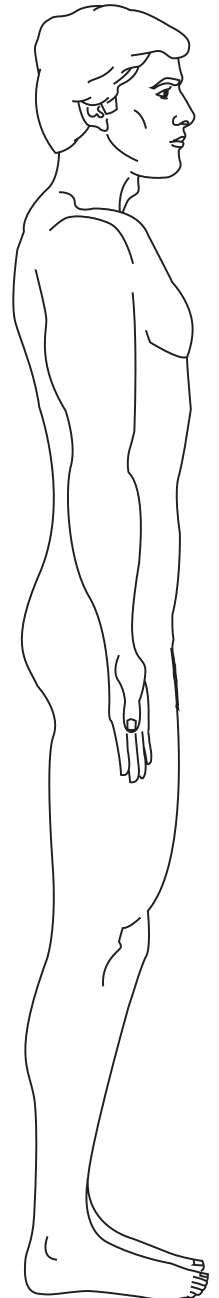

RIGHT

WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON? YES NO

Name________________________ When ________________________

Diagnosis________________________ Surgery (See Below)

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

WERE YOU EVER ADMITTED TO THE HOSPITAL FOR THIS PROBLEM? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

DID YOU EVER HAVE X-RAYS TAKEN OF YOUR SPINE? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

DID YOU HAVE A CAT SCAN OR MRI DONE? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

DID YOU HAVE AN EMG/NCV DONE? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

HAVE YOU EVER HAD PHYSICAL THERAPY (PT), A CORSET OR A BRACE? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

DID YOU HAVE A MYELOGRAM (dye test) DONE? YES NO

Name ________________________ When ________________________

Diagnosis ________________________ Treatment ________________________

HAVE YOU EVER HAD AN EPIDURAL CORTISONE INJECTION (Meat tenderizer)? YES NO

When ________________________ Where ________________________

Results________________________ Doctor ________________________

HAVE YOU EVER HAD SPINE SURGERY (Laminectomy or Fusion)? YES NO

#1 When ________________ Hospital ________________________

Results________________________ Doctor ________________________

#2 When ________________ Hospital ________________________

Results________________________ Doctor ________________________

#3 When ________________ Hospital ________________________

Results________________________ Doctor ________________________

#4 When ________________ Hospital ________________________

Results________________________ Doctor ________________________

THANK YOU FOR YOUR PATIENCE IN FILLING OUT THIS FORM!