SOUTHERN ORTHOPEDIC
SPINE SURGERY
DR. GAISER

Date: _____

Spine Evaluation

Please take a moment to fill out this questionnaire. Please answer all the questions to the best of your ability. Your response will allow us to assess how your back is doing and track your progress over time. Thank you!

Name: _____

DOB: _____ **Sex: M___ F___** **Occupation: _____**

Referring Doctor: _____

Pain Profile:

1) Where is the primary location of your pain?

Neck___ Upper Back___ Mid Back___ Lower Back ___ Arms___ Legs___

2) How long ago did your current episode begin? (Choose one)

____ Less than 2 weeks ago
____ 2 - 4 weeks ago
____ 1-2 months ago
____ 2 - 4 months ago
____ 4 - 6 months ago
____ 6 - 12 months ago
____ More than 12 months ago

3) How did your current episode begin?

____ Suddenly
____ Gradually

4) Briefly describe your current pain when it first started: _____
_____
_____

5) Has your current pain changed in any way since it started? If so, describe: _____
_____
_____

6) **Have you had neck or back problems in the past?** Yes ____ No____
If no, please skip to question 10. If yes, please describe: _____
_____
_____

7) If injured, did this injury occur at work? Yes ____ No____

8) Did you receive Worker's Compensation for your past back symptoms?
Yes____ No____ Not Applicable____

9) How much work did you miss because of your worst prior episode? (Choose one)
____ None
____ Less than 2 weeks
____ More than 2 weeks
____ More than 4 weeks
____ More than 12 weeks
____ More than 24 weeks

10) Your current pain is: (Check where appropriate)

Better	Worse	No Change	
_____	_____	_____	When coughing or sneezing
_____	_____	_____	Bending forward
_____	_____	_____	Bending backward
_____	_____	_____	Using the bathroom

11) What do you do in order to ease your pain? _____

_____

_____

12) If 0 (zero) is no pain and 10 (ten) is the worst pain you can imagine:

- At the most severe, you would rate your pain as: ____
- At the least severe, you would rate your pain as: ____
- Today, you would rate your pain as: ____

13) Have you ever had surgery on your spine?

Neck: Yes____ No ____ If yes, when: _____ # of times: ____

Back: Yes____ No ____ If yes, when: _____ # of times: ____

14: Have you ever had any of the following tests?

	Yes	No	Number of times	Dates (estimation)
CT/CAT Scan	____	____	____	_____
MRI	____	____	____	_____
CT Myelogram	____	____	____	_____
EMG/NCV Study	____	____	____	_____

If you have had any of these tests performed, did you bring the results with you? _____

Is this visit for a second opinion? _____

15) Within the last 6 months, which of the following types of treatment have you have?

			Did it help?	
	Did not have	No	Yes	No change
Physical therapy:	_____	___	___	_____
Chiropractor manipulation:	_____	___	___	_____
Traction:	_____	___	___	_____
Formal exercise program:	_____	___	___	_____
Aquatic (water) therapy:	_____	___	___	_____
Cortisone injections:	_____	___	___	_____
Steroid treatment with pills:	_____	___	___	_____
Anti-inflammatory medication:	_____	___	___	_____
Muscle Relaxors:	_____	___	___	_____
Epidural Steroid Injections:	_____	___	___	_____