Chattanooga Spine and Body

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Initial Patient Questionnaire

Date: _____

Patient Name: Last: _____ **First:** _____

Date of Birth: _____ **SSN:** _____

Chief Complaint

Location of pain (where): _____

Pain has been present for (days/weeks/months/years): _____

Pain is (chronic/intermittent): _____

Pain worse (time of day): _____

Pain worse with (activities): _____

Pain better with: _____

Previous treatments: _____

Previous medications: _____

Past Medical History

Hypertension:	Yes / No	Kidney Failure:	Yes / No
Heart Disease:	Yes / No	Kidney Failure (dialysis):	Yes / No
COPD/Emphysema:	Yes / No	Blood transfusions:	Yes / No
Asthma:	Yes / No	Bleeding Disorder:	Yes / No
Tuberculosis:	Yes / No	Circulatory Disorder:	Yes / No
Diabetes Type 1 (Insulin):	Yes / No	Peripheral Neuropathy:	Yes / No
Diabetes Type 2 (Non-Insulin):	Yes / No	Anxiety:	Yes / No
High Cholesterol:	Yes / No	Panic Attacks:	Yes / No
Stroke/CVA:	Yes / No	Depression:	Yes / No
Stomach Ulcer:	Yes / No	Insomnia:	Yes / No
Acid Reflux:	Yes / No	Blood Disease:	Yes / No
Liver Disease:	Yes / No	Past Pregnancies:	Yes / No
Kidney Disease:	Yes / No		

Other: _____

Past Surgical History

General Surgeries: _____

Orthopedic Surgeries: _____

Trauma Surgeries: _____

Other Surgeries: _____

Hopitalizations

Reason/Location/Year: _____

Reason/Location/Year: _____

Reason/Location/Year: _____

Family History

Father: Living- Yes / No Cause of Death: _____ Age: _____

Medical History: _____

Mother: Living- Yes / No Cause of Death: _____ Age: _____

Medical History: _____

Brothers: (#) _____

Medical History: _____

Sisters: (#) _____

Medical History: _____

Social History

Marital Status: Married / Single / Divorced / Separated / Widowed Number of Children:

Living Situation: Alone / Spouse / Family / Friend(s)

Level of Education: No school / High School / GED / Some College / College Graduate / Post Graduate

Tech School

Tobacco Use (Cigarettes, Cigars, Chew/Dip): ____ (cigarettes / packs) per _____ (day / week / month)

Alcohol Use: _____ Drinks per: Day / Week / Month / Rarely / Never

Recreational Drug Use:

Kind of Home: House / Apartment / Manuf. Home / Condo / Assist. Living

Number of stories in home: _____ Number of steps to enter home: _____

Work Status (as described by patient)

Working: Full-time regular / Full-time modified / Part-time regular / Part-time modified

Occupation: _____

Self-employed / Homemaker / Retired / Disabled / Unemployed / Fired / Laid off/ Student / Stopped work because of pain

Current Medications

	Name	Dosage (mg)	Times/day
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

6. _____ _____ _____
7. _____ _____ _____
8. _____ _____ _____
9. _____ _____ _____
10. _____ _____ _____
11. _____ _____ _____
12. _____ _____ _____
13. _____ _____ _____

Allergies

Medication	Reaction Type
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Other Allergies

Betadine:	Yes / No	X-ray Contrast:	Yes / No
Steroids:	Yes / No	Latex:	Yes / No
Adhesive Tape:	Yes / No	Lidocaine:	Yes / No

Other: _____

Review of Systems

General:

Recent loss of appetite	Yes / No
Recent unplanned weight loss	Yes / No
Fevers, chills, or sweats	Yes / No
Fatigue	Yes / No

Eyes:

Blurred/double vision	Yes / No
Worsening Vision	Yes / No
Glaucoma	Yes / No
Cataracts	Yes / No
Contacts / Glasses	Yes / No

Ear, Nose, and Throat:

Ringing in ears	Yes / No
Worsening in hearing	Yes / No
Difficulty swallowing	Yes / No
Frequent nose bleeds	Yes / No

Cardiovascular:

Chest pain	Yes / No
Fainting spells	Yes / No
Palpitations	Yes / No
Shortness of breath w/ exertion	Yes / No

Respiratory:

Cough	Yes / No
Chronic shortness of breath	Yes / No
Chronic wheezing	Yes / No
Excessive phlegm	Yes / No

Genitourinary:

Unusual vaginal discharge	Yes / No
Loss of control of urine	Yes / No
Painful urination	Yes / No
Blood in urine	Yes / No
Increased urination	Yes / No
Frequent urination at night	Yes / No

Psychological:

Feeling depressed/sad	Yes / No
Memory loss	Yes / No
Difficulty concentrating	Yes / No
Phobias/uncontrollable fears	Yes / No

Endocrine:

Cold/heat intolerance	Yes / No
Increased thirst/urination	Yes / No
Significant weight change	Yes / No

Musculoskeletal:

Back pain	Yes / No
Neck pain	Yes / No
Joint pain	Yes / No
Swelling in joints	Yes / No
Muscle cramping	Yes / No
Muscle stiffness	Yes / No
Arthritis	Yes / No

Gastrointestinal:

Nausea/vomiting	Yes / No
Diarrhea	Yes / No
Constipation	Yes / No
Abdominal pain	Yes / No
Bloody/black stools	Yes / No

Skin:

Skin rashes	Yes / No
Itching	Yes / No
Chronic dry skin	Yes / No

Blood/Lymphatic:

Easy bruising	Yes / No
Easy bleeding	Yes / No
Enlarged lymph nodes	Yes / No

Allergy/Immunologic:

Hives	Yes / No
Frequent infections	Yes / No
Seasonal allergies	Yes / No

Neurological:

Migraine headaches	Yes / No
General headaches	Yes / No
Inability to move body parts	Yes / No
Muscle weakness	Yes / No
Numb/tingling sensations	Yes / No
Seizures/convulsions	Yes / No
Fainting spells	Yes / No
Dizziness/vertigo	Yes / No
Tremors	Yes / No

Other

Please list any other medical conditions not listed above:

_____