INITIAL VISIT QUESTIONNAIRE
FILL THIS OUT BEFORE YOUR APPOINTMENT

NeuroSpine CENTER OF WISCONSIN

DO NOT WRITE HERE - Reserved for clinician notes

ABOUT YOU

Name: _____ Today's date: _____
Birth date: _____ Your age: _____ Are you right or left handed? _____
Who is your primary doctor for general medical problems? _____
Who referred you to us? [ ] Your primary doctor [ ] Other: _____

ABOUT YOUR MEDICAL PROBLEMS

List the problems or concerns you want us to address, starting with the most important:
[1] _____
[2] _____
[3] _____

When did the primary problem start (exact date, if possible)? _____

Did it come on: [ ]instantly [ ]over minutes to hours [ ]over days [ ]other

What brought it on? _____

Are there any activities or positions that significantly worsen your symptoms?
[ ]sitting [ ]standing [ ]walking [ ]lifting [ ]bending [ ]other (list): _____

Are there any activities or positions that significantly improve your symptoms?
[ ]sitting [ ]standing [ ]walking [ ]lifting [ ]bending [ ]other (list): _____

With time, are your symptoms: [ ]improving [ ]staying the same [ ]worsening

Did you ever have any problems in this area of your body before this? [ ]No [ ]Yes
If yes, please describe: _____
_____

PREVIOUS EVALUATIONS

What other doctors, therapists, or chiropractors have you seen for this problem?

Name	Specialty	Approximate date seen

What tests were done?

Name of test and body area studied	Date	Where done	Result, if known
[ ] X-ray of:			
[ ] MRI Scan of:			
[ ] CAT Scan of:			
[ ] Myelogram:			
[ ] Radioactive Bone Scan:			
[ ] EMG:			
[ ] Angiogram			
[ ] Blood tests:			

PREVIOUS TREATMENTS

MEDICATIONS

What medications have you tried for this problem? *(Medications for other problems will be asked later)*

(Write medication name & dose below)	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still use this	If no longer using, why not?
_____	[ ]	[ ]	[ ]	[ ]	[ ]	
_____	[ ]	[ ]	[ ]	[ ]	[ ]	
_____	[ ]	[ ]	[ ]	[ ]	[ ]	
_____	[ ]	[ ]	[ ]	[ ]	[ ]	
_____	[ ]	[ ]	[ ]	[ ]	[ ]	

PHYSICAL THERAPY	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still use this	How many times a month do you still do this?
[ ] Ice / Heat / Ultrasound	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Massage	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Electrical stimulation	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Traction	[ ]	[ ]	[ ]	[ ]	[ ]	
[ ] Exercise	[ ]	[ ]	[ ]	[ ]	[ ]	

CHIROPRACTIC	Helped A Lot	Helped A Little	No Effect	Made Worse	Check if you still go	How many times a month do you still go?
[ ] Manipulation	[ ]	[ ]	[ ]	[ ]	[ ]	

INJECTIONS Area of body injected	Helped A Lot	Helped A Little	No Effect	Made Worse	Physician	Date(s) Injected
_____	[ ]	[ ]	[ ]	[ ]		
_____	[ ]	[ ]	[ ]	[ ]		

PAST MEDICAL HISTORY

Have you been diagnosed with any other medical problems? Check all that apply:

[ ] High blood pressure
[ ] High cholesterol
[ ] Diabetes
[ ] Cancer
[ ] Osteoarthritis
[ ] Rheumatoid arthritis
[ ] Gout
[ ] Thyroid disease
[ ] Osteopenia/osteoporosis
[ ] Migraine headaches
[ ] Stroke or TIA
[ ] Severe head injury
[ ] Brain aneurysm
[ ] Seizures
[ ] Tuberculosis
[ ] Emphysema or asthma
[ ] Sleep apnea
[ ] Heart attack or angina
[ ] Irregular heart beat
[ ] Abnormal heart valve
[ ] Aortic aneurysm
[ ] Poor circulation
[ ] Ulcers in stomach or intestines
[ ] Kidney problems
[ ] Liver problems
[ ] Bowel problems
[ ] Easy bleeding
[ ] Blood clots
[ ] Fibromyalgia
[ ] Depression
[ ] Anxiety disorder
[ ] Other mental illness _____
[ ] Addiction to alcohol
[ ] Addiction to other drugs
[ ] HIV/AIDS
[ ] Major trauma (accidents, falls)
[ ] Broken bones
[ ] Prolonged prednisone use
[ ] OTHER: _____

PAST SURGICAL HISTORY

Type of surgery	Why was it done?	Surgeon	Hospital	Date

HOSPITALIZATIONS

Have you been hospitalized for reasons other than the above surgeries?

Reason for Hospitalization	When?

MEDICATIONS

What prescription medicines do you take? (List here, or bring a list if you have one).

Name of medicine	What is this for?	Dose and frequency	When did you start taking this?

What non-prescription medicines do you take? ***(Include aspirin, if applicable)***

Name of medicine	What is this for?	Dose and frequency	When did you start taking this?

ALLERGIES

Are you allergic to iodine, shellfish, or contrast dye? [ ]No [ ]Yes

Are you allergic to any medicines? [ ]No [ ]Yes If yes, list medicine(s) and the reaction(s) you have:

REVIEW OF SYSTEMS

Check all that you have had in the last 3 months:

[ ] Fevers or chills
[ ] Unexpected weight loss of more than 10 pounds
[ ] Difficulty sleeping
  If "YES", how long does it take to fall asleep? .....
  How many times a night do you awaken? .....
[ ] Long breathing pauses while sleeping
[ ] Loss of vision or double vision
[ ] Difficulty swallowing, smelling, or hearing
[ ] Swelling in feet or ankles
[ ] Chest pain or tightness
[ ] Shortness of breath
[ ] Coughing or coughing up blood
[ ] Stomach or belly pain
[ ] Nausea and/or vomiting
[ ] Problems with bowel movements:
  [ ] Constipation
  [ ] Diarrhea
  [ ] Accidental bowel movements
  [ ] Bloody or black stools
[ ] Problems with urination:
  [ ] Accidental urination
  [ ] Inability to urinate
  [ ] Urge to urinate more frequently than usual
  [ ] Burning, foul smelling, cloudy or bloody urine
[ ] Problems with sexual function
[ ] Leg cramps when walking or at night
[ ] Skin rashes
[ ] Depression
[ ] Frequent headaches
[ ] Unconsciousness
[ ] Difficulty talking
[ ] Poor coordination
[ ] Difficulty walking
[ ] Loss of balance / falling
[ ] Numbness or tingling in arms, forearms, or hands
[ ] Weakness in arms, forearms, or hands
[ ] Numbness or tingling in thighs, legs, or feet
[ ] Weakness in thighs, legs, or feet

If you are female:

Is there any chance you could be pregnant now? [ ]No [ ]Yes

Are your symptoms worsened near your period? [ ]No [ ]Yes [ ] Not applicable

What exercises do you do regularly?

Type of exercise	Minutes each session	How many times a month?

FAMILY HISTORY

What diseases run in your grandparents, parents, siblings, and children?

	Who has or had this?		Who has or had this?
[ ] Diabetes		[ ] Reaction to anesthesia	
[ ] Cancer		[ ]	
[ ] Heart disease		[ ]	
[ ] Stroke		[ ]	

SOCIAL HISTORY

Do you use caffeine?	[ ]No, or very rarely [ ]Yes, up to _____ cups/cans of caffeinated pop, tea or coffee daily.
Do you use alcohol?	[ ]No, or very rarely [ ]I used to drink, but quit in _____ [ ]Yes, up to _____ drinks a day at most.
Do you smoke?	[ ]No, I have never smoked [ ]I used to smoke, but quit in _____ [ ]I smoke now, _____ packs per day. I've smoked for _____years.
Do you chew tobacco?	[ ]No [ ]Yes

Are you: [ ]single [ ]married [ ]divorced [ ]widowed [ ]other

How many years of school did you complete? _____ Your occupation: _____
Are there any lawsuits related to your problem? [ ]No [ ]Yes
Are you receiving disability income? [ ]No [ ]Yes

WORK HISTORY (Complete if your problem started at work, or is interfering with work)

Did your symptoms start at work? [ ]No [ ]Yes [ ] Unsure
Is your problem covered by Worker's Compensation? [ ]No [ ]Yes [ ] Unsure

	At the time of your injury	**Now**
Your employer:		
Your job title:		
Hours worked per week:		
Heaviest load you *frequently* lift at work:		
Heaviest load you *ever* lift at work:		

If you reduced your work hours, on what date did you reduce your hours? _____

Are you under a doctor's work restrictions for this problem? [ ]No [ ]Yes
If "YES", which physician gave you restrictions? _____
If "YES", exactly what restrictions are you under? _____
_____

Thank you for filling out this questionnaire!

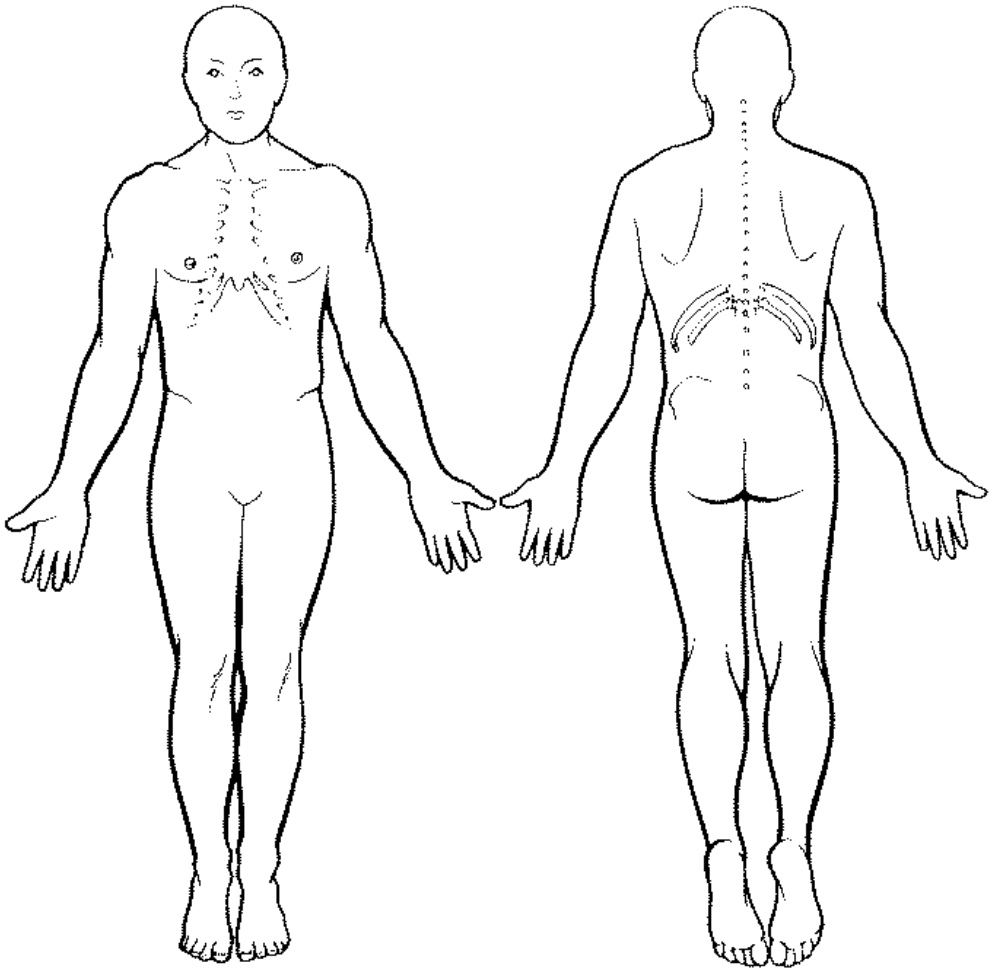
_____ _____ _____ _____
Please sign your name here Date NeuroSpine doctor will sign here Date

IF YOUR PROBLEM INVOLVES PAIN, TINGLING, OR NUMBNESS, COMPLETE THIS PAGE.

PAIN DIAGRAM

Please draw where you feel your symptoms. Use the appropriate symbols.

Aching Pain | Stabbing Pain (X) | Burning Pain (o o o / o o o / o o o) | Pins & Needles | Complete Numbness



Right Left — FRONT VIEW

Left Right — BACK VIEW

Circle how severe your symptoms have been, on average, over the last 2 weeks.

- "0" is no pain at all.
- "10" is severe pain.

Back or neck symptoms	0	1	2	3	4	5	6	7	8	9	10
Arm or leg symptoms	0	1	2	3	4	5	6	7	8	9	10

Least severe — Most severe