Weill Cornell Brain and Spine Center

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SPINE CENTER NEW PATIENT QUESTIONNAIRE

Patient Name_____ **Patient's Date of Birth** ___/___/____ **Today's Date:** ___/___/____

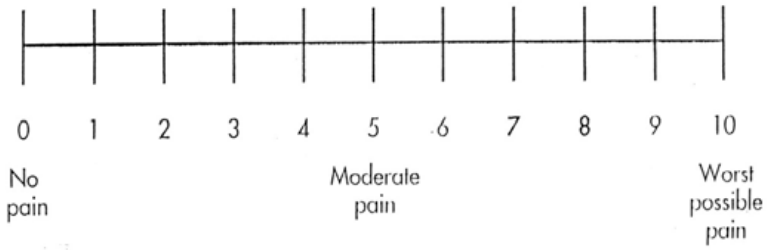
Gender: M / F Patient's Phone Number ( )_____ **Patient's Cell Phone ( )** _____

How did you hear about us? _____ **If referred by MD, name:** _____

If referred by MD, phone_____

Symptoms/Reason for visit: _____

On the diagram below, write X to indicate the severity of pain you are having right now.
Write L to indicate least pain. Write W, to indicate worst pain.



Did an accident or other event precipitate your pain? ☐YES ☐ NO

If yes, please describe: _____

_____

_____

Were you injured at work? ☐YES ☐ NO

Are you filing for Worker's Comp? ☐ YES ☐ NO

Are you currently involved in litigation? ☐YES ☐ NO

When did the pain start? _____

_____

Frequency of pain:
_____times a day
_____times a week
_____times a month

Duration of pain:
_____ seconds
_____ minutes
_____ hours

Do you experience…
☐Weakness ☐Numbness ☐Tingling

When is the pain worst?
☐Morning ☐Afternoon ☐Evening ☐ Night
☐Changing position

Describe pain:
☐Burning ☐ Sharp ☐ Shooting
☐Dull ☐ Numbness ☐ Electrical
☐Throbbing ☐ Aching ☐Cramps
☐Gripping ☐ Pins/Needles

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Name: _____ Date: _____

Pain interferes with (check all that apply):

☐ Appetite ☐ Sleep ☐ Sex
☐ Self-care ☐ Hobbies ☐ Job performance
☐ Social life ☐ Exercise ☐ Travelling
☐ Lifting ☐ Shopping ☐ House chores
☐ Driving ☐ Cooking

If pain limits activity, please fill in all that apply:

I can't tolerate **walking** more than _____blocks.
I can't tolerate **sitting** more than _____ minutes.
I can't tolerate **standing** more than _____ minutes.
I can't tolerate **lying** more than _____ minutes.

Other functional limitations: _____

_____

What makes pain better?

_____

_____

What makes pain worse?

_____

_____

Below, indicate past treatments for pain:

Type	Date
Nerve Blocks	
Steroid Injections	
Physical therapy	
Psychotherapy	
Acupuncture	
Surgery	
Chiropractic	
Failed Meds	
Other	

Have you had any of the following imaging studies?

☐Xray ☐ CT Scan ☐MRI ☐Bone Scan ☐EMG
Other: _____

If yes, please list dates of scans: _____

Are you right- or left-handed? ☐Right ☐Left

What is your occupation? _____

Current Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Any Allergies To: ☐Shellfish ☐Iodine ☐Latex

☐ Contrast/IV Dye ☐Other **(please list below)**

Allergies	Reaction
1.	
2.	
3.	
4.	

Social History:

Do you smoke? ☐Yes ☐ No

Have you quit? ☐Yes When? _____
Type: _____ Packs/day: _____ Years: _____

Do you use chewing tobacco or snuff? ☐Yes ☐ No

Have you quit? ☐Yes When? _____

Do you drink alcohol? ☐Yes ☐ No
Type: ____ Amount: ____ How often: _____

Do you use illicit (street) drugs? ☐Yes ☐ No
Type of drug(s): _____ Last used: _____

Marital Status: ☐Single ☐ Married ☐ Cohabitating

☐Separated ☐Divorced ☐Widowed

Who do you live with? ☐Alone ☐Spouse ☐Children ☐Parents
Other: _____

_____

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Name: _____ **Date:** _____

Past Medical History: _____

_____

Past Surgical History and Dates: _____

Family Medical History: _____

Review of Systems (check all that apply):

General: ☐Weight loss/gain ☐Fatigue ☐Fever ☐Other _____

Hearing/ENT: ☐Glaucoma ☐Cataract ☐Hearing Loss ☐Other _____

Cardiovascular: ☐Heart Attack ☐Chest pain ☐Heart Murmur ☐Hypertension ☐Claudication
☐Irregular heartbeat ☐AICD/Pacemaker ☐Heart failure ☐Stent ☐ Other_____

Respiratory: ☐Asthma ☐Emphysema ☐Shortness of Breath ☐Cough ☐Bronchitis
☐Sleep Apnea ☐Pulmonary Embolus ☐TB ☐Other _____

Gastrointestinal: ☐GERD ☐Peptic Ulcer Disease ☐Diverticulitis ☐Irritable bowel ☐Hepatitis
☐Cirrhosis ☐ Hyperlipidemia ☐Gall Bladder Disease ☐Other _____

Genitourinary: ☐Renal Failure ☐Transplant ☐Dialysis ☐Enlarged prostate (BPH) ☐Other _____

Musculoskeletal: ☐Rheumatoid arthritis ☐Other _____

Neurological: ☐Stroke ☐ Seizures ☐Dizziness ☐Other _____

Psychiatric: ☐Depression ☐Anxiety ☐Bipolar ☐Other _____

Endocrine/Metabolic: ☐Diabetes ☐Lupus ☐Thyroid disease ☐Other _____

Hematologic/ Lymphatic: ☐Anemia ☐DVT ☐Bleeding/Clotting problems ☐Other _____

Females: LMP: _____ Please notify MD/NP/RN/PA, if you are pregnant. ☐Yes ☐No

Cancer: ☐Yes ☐No If yes, type: _____ Chemo: ☐Yes ☐No Radiation: ☐ Yes ☐No

Preferred Pharmacy:

Name: _____ Phone#: _____ Address: _____

Patient Signature: _____ Date: _____

If this form was completed by someone other than the patient, please list name, relation to the patient and the reason that the patient was unable to complete the form:

_____

Form completed by: _____ Date: _____

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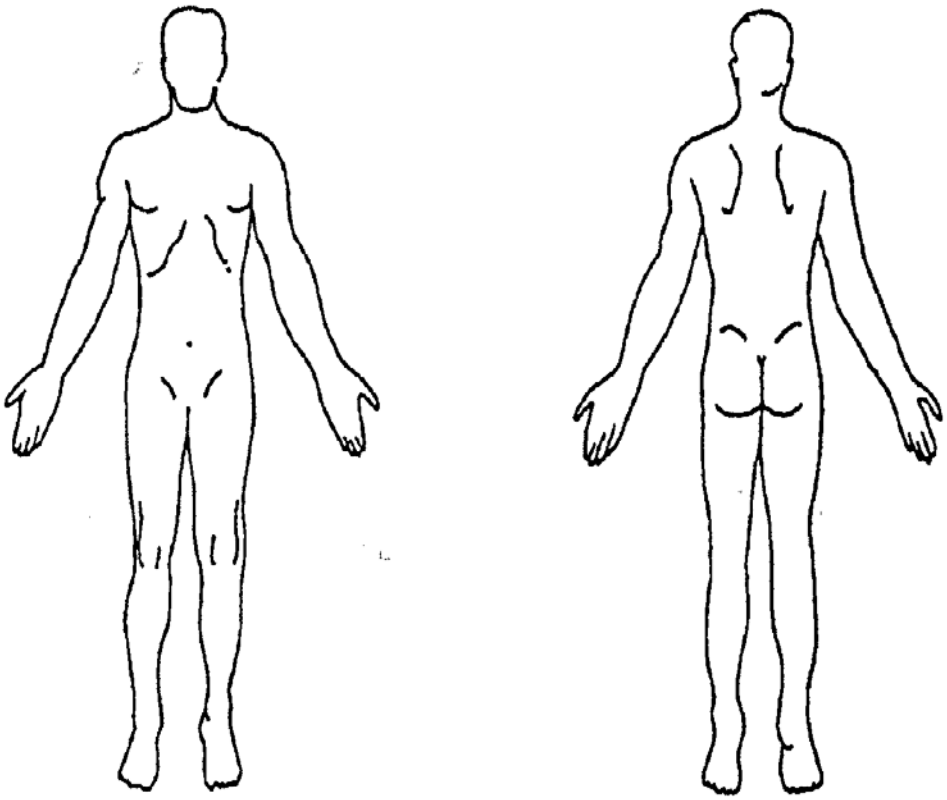
Name: _____ Date: _____

On the diagram below, please indicate where you are experiencing pain or other symptoms at this time.



Front *Back*

A= ACHE

B= BURNING

N= NUMBNESS

P= PINS/NEEDLES

S= STABBING

T= TINGLING

O= OTHER

On a scale from 0 to 10, please circle your level of pain or discomfort, with 0 being none and 10 being unbearable for the following areas:

1.	Neck Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
2.	Left Shoulder Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
3.	Right Shoulder Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
4.	Left Arm Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
5.	Right Arm Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
6.	Back Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
7.	Left Hip/Buttock Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
8.	Right Hip/Buttock Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
9.	Left Leg Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)
10.	Right Leg Pain	(None)	0	1	2	3	4	5	6	7	8	9	10	(Unbearable)

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Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at All**	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

(For office coding: Total Score: _____=_____+_____+_____

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Oswestry Disability Questionnaire

Name: _____

This questionnaire has been designed to give us information as to how your **back or leg pain** is affecting your ability to manage in everyday life. Please answer by checking **one circle in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which **most clearly describes your problem**.

Section 1: Pain Intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but can manage most of my personal care
- o I need help every day in most aspects of self-care
- o I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives me extra pain
- o Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- o Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- o I can only lift very light weights
- o I cannot lift or carry anything

Section 4: Walking*

- o Pain does not prevent me walking any distance
- o Pain prevents me from walking more than 1 mile
- o Pain prevents me from walking more than ½ mile
- o Pain prevents me from walking more than 100 yards
- o I can only walk using a stick or crutches
- o I am in bed most of the time

Section 5: Sitting

- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me sitting more than one hour
- o Pain prevents me from sitting more than 30 minutes
- o Pain prevents me from sitting more than 10 minutes
- o Pain prevents me from sitting at all

Section 6: Standing

- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing for more than 1 hour
- o Pain prevents me from standing for more than 30 minutes
- o Pain prevents me from standing for more than 10 minutes
- o Pain prevents me from standing at all

Section 7: Sleeping

- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain I have less than 6 hours sleep
- o Because of pain I have less than 4 hours sleep
- o Because of pain I have less than 2 hours sleep
- o Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9: Social Life

- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- o Pain has restricted my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10: Traveling

- o I can travel anywhere without pain
- o I can travel anywhere but it gives me extra pain
- o Pain is bad but I manage journeys over two hours
- o Pain restricts me to journeys of less than one hour
- o Pain restricts me to short necessary journeys under 30 minutes
- o Pain prevents me from travelling except to receive treatment

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Name: _____Age:_____ Date:_____

PLEASE READ*: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity A I have no pain at the moment. B The pain is very mild at the moment. C The pain is moderate at the moment. D The pain is fairly severe at the moment. E The pain is very severe at the moment. F The pain is the worst imaginable at the moment.	***SECTION 6 - Concentration*** A I can concentrate fully when I want to with no difficulty. B I can concentrate fully when I want to with slight difficulty. C I have a fair degree of difficulty in concentrating when I want to. D I have a lot of difficulty in concentrating when I want to. E I have a great deal of difficulty in concentrating when I want to. F I cannot concentrate at all.
SECTION 2 -Personal Care (Washing, Dressing, etc.) A I can look after myself normally without causing extra pain. B I can look after myself normally, but it causes extra pain. C It is painful to look after myself and I am slow and careful. D I need some help, but manage most of my personal care. E I need help every day in most aspects of self care. F I do not get dressed, I wash with difficulty and stay in bed.	***SECTION 7 - Work*** A I can do as much work as I want to. B I can only do my usual work, but no more. C I can do most of my usual work, but no more. D I cannot do my usual work. E I can hardly do any work at all. F I cannot do any work at all.
SECTION 3 - Lifting A I can lift heavy weights without extra pain. B I can lift heavy weights, but it gives extra pain. C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. E I can lift very light weights. F I cannot lift or carry anything at all.	***SECTION 8 - Driving*** A I can drive my car without any neck pain. B I can drive my car as long as I want with slight pain in my neck. C I can drive my car as long as I want with moderate pain in my neck. D I cannot drive my car as long as I want because of moderate pain in my neck. E I can hardly drive at all because of severe pain in my neck. F I cannot drive my car at all.
SECTION 4 - Reading A I can read as much as I want to with no pain in my neck. B I can read as much as I want to with slight pain in my neck. C I can read as much as I want to with moderate pain in my neck. D I cannot read as much as I want because of moderate pain in my neck. E I cannot read as much as I want because of severe pain in my neck. F I cannot read at all.	***SECTION 9 - Sleeping*** A I have no trouble sleeping. B My sleep is slightly disturbed (less than 1 hour sleepless). C My sleep is mildly disturbed (1-2 hours sleepless). D My sleep is moderately disturbed (2-3 hours sleepless). E My sleep is greatly disturbed (3-5 hours sleepless). F My sleep is completely disturbed (5-7 hours)
SECTION 5 - Headaches A I have no headaches at all. B I have slight headaches which come infrequently. C I have moderate headaches which come infrequently. D I have moderate headaches which come frequently. E I have severe headaches which come frequently. F I have headaches almost all the time.	***SECTION 10 - Recreation*** A I am able to engage in all of my recreational activities with no neck pain at all. B I am able to engage in all of my recreational activities with some pain in my neck. C I am able to engage in most, but not all of my recreational activities because of pain in my neck. D I am able to engage in a few of my recreational activities because of pain in my neck. E I can hardly do any recreational activities because of pain in my neck. F I cannot do any recreational activities at all.

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