HOUSTON SPINE INSTITUTE

PATIENT QUESTIONAIRE FORMS

Please check answers to questions that pertain to your problem. You may select more than one answer per questions. This information will help get an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit note. If you have any questions, please ask for assistance.

Referred By____. Is this a second opinion? _______________.

NAME: ____. DATE_____________. Date of Birth_________

AGE______SEX: ☐Male ☐Female ARE YOU: ☐Right Handed ☐Left Handed ☐Ambidextrous

CURRENT MEDICATIONS:

Name	Dose	for what problem?

ALLERGIES:

☐ No known Drug Allergies? Including iodine/contrast dye or shellfish

☐ Yes, Please List____

COMPLAINT/PAIN (What are you being seen for?)

☐ **KNEE PAIN/INJURY**	☐**ANKLE PAIN/INJURY**	☐**FOOT PAIN/INJURY**
KNEE ☐ R ☐ L	ANKLE ☐ R ☐ L	FOOT ☐ R ☐ L
☐ Pain Worse with Weight bearing	☐ Ankle Joint Swelling	☐ Swelling of foot
☐ Knee Joint Pain is increased	☐ Ankle Joint Stiffness	☐ Foot Instability
☐ Knee Joint Pain is Improved	☐ Pain worsens with Weightbearing	☐ Foot pain with Weightbearing
☐ Knee Joint Swelling	☐ Pain worsens with foot movement	
☐ Knee Joint Stiffness	☐ Ankle pain is improved	
☐ Popping sound in Knee	☐ Ankle Swelling Improves	
☐ Soft tissue Knee pain	☐ Instability of Ankle	
☐ Knee Dislocation		

REPORTED TRAUMA: ☐Right Knee ☐ Left knee ☐ Right Ankle ☐ Left Ankle ☐ Right Foot ☐ Left Foot ☐ Difficulty walking

PAIN LEVEL: _____/10 (Scale of 0 to 10)

Pain Describes As?

☐ Aching ☐ Shooting ☐Sharp ☐Burning ☐Tiring ☐Penetrating ☐Unbearable

☐ Throbbing ☐ Stabbing ☐ Nagging ☐ tender

Pain Moves: ☐Yes ☐ No

Pain Frequency: ☐ Always Present ☐Usually Present ☐ Often Present ☐ Occasionally Present

Pain Associated With: ☐ Numbness ☐Muscle spasms ☐Tingling ☐ Feelings of weakness

Pain Worse With: ☐ Sitting ☐ Physical Activity ☐ Cough ☐Lying ☐ Walking ☐ Standing

Pain Better With: ☐Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Heating Application ☐Relaxation technique ☐ Physical Activity ☐ Drinking Alcohol

Self Assessment: ☐Felling Hopeless ☐ Felling Helpless

Pain began/How did the injury occur? ☐ Playing Sports ☐ Accident at work ☐ Work-Related event ☐ Home Accident ☐ Recent Surgery ☐Motor vehicle Accident ☐ None

Previous History of: ☐ Knee joint Pain ☐ Ankle joint Pain ☐ Foot Pain
Date of Injury/ When did this problem start? ______________________________
Please briefly explain the circumstances that led to your condition:
____
____
____
____

PREVOUS TREATMENTS: ☐ Ortho Splinting/cast ☐ EMG test ☐ MRI ☐ X-Ray ☐ Acupuncture ☐ Chiropractor ☐ Physical Therapy ☐ Injections ☐ Pain medication

PAST MEDICAL HISTORY: Do you have any of these medical conditions?

☐ Headache ☐ Abdominal pain ☐Anxiety ☐Kidney Disease ☐ Seizure ☐ Cataract
☐ Coronary Artery ☐ Hypertension ☐ Heart Disease ☐ Pneumonia ☐ Asthma ☐ COPD
☐ Emphysema ☐Esophageal Reflex ☐ Gastric Reflex ☐ Hemorrhoids ☐Liver Disease ☐Hyperlipidemia
☐ Obesity ☐Thyroid Disease ☐Osteoporosis ☐Diabetes ☐ Psoriasis ☐ Arthritis
☐ Gout ☐ SLE ☐ Stroke ☐ Depression ☐ Sleep Apnea ☐Tuberculosis
☐ Hematologic Disorder ☐ Anemia ☐ Cancer ☐Other ____________

PAST SURGICAL HISTORY:

☐ Neck Surgery ☐ Appendectomy ☐ Cholecystectomy ☐ Hysterectomy ☐ C – Section
☐ Tonsillectomy ☐ Lumbar Spine Fusion ☐ Back Surgery ☐ Lumbar Disc surgery ☐ Shoulder Surgery
☐ Hip Surgery ☐ Knee Surgery ☐ Ankle Surgery ☐ Foot Surgery

SOCIAL AND FAMILY HISTORY

Do you smoke ☐No ☐ Current Smoker ☐ Previous Smoker
Alcohol ☐No ☐Yes ☐ Occasionally
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
What is the highest level of education you have completed?
☐Some high School ☐High School ☐Trade School ☐College ☐Professional School
Current Employment Status:
☐ Regular ☐part time ☐retired ☐Unemployed ☐ Student ☐other ____________
OCCUPATION: ____________________

FAMILY HISTORY: Do you have any family history of any of these diseases? (Check all that are appropriate)

☐None ☐ Heart Disease ☐ Family History of bleeding ☐ Coronary Artery disease ☐Hypertension
☐ Asthma ☐ COPD ☐ Renal Disease ☐ Hyperlipidemia ☐ Thyroid Disease ☐ Osteoporosis
☐ Diabetes Mellitus ☐ Stroke ☐ Hematologic Disorder ☐ Cancer

REVIEW OF SYSTEMS (check all that appropriate)

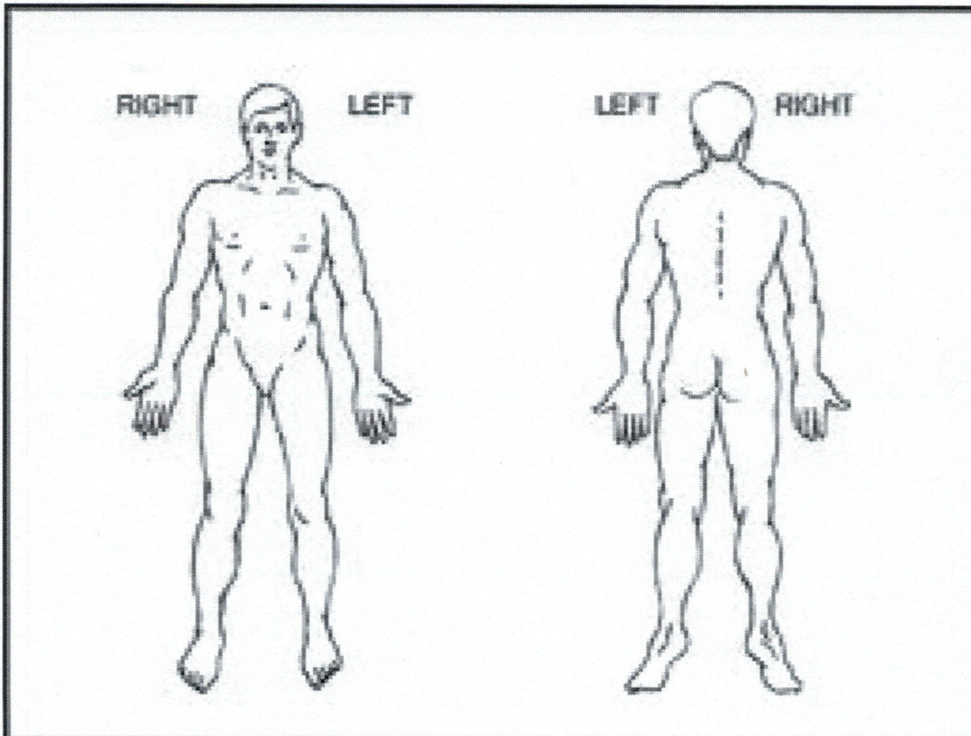
SYSTEMIC:	☐ Feeling fatigued	☐ Fever	☐ Chills	☐ Recent Weight loss	☐ Recent Weight gain
HEAD	☐ Headache	☐ Sinus Pain			
EYES:	☐ Worsening vision	☐Floaters	☐ Blurry Vision		
ENT:	☐ Hearing loss	☐ Earache	☐ Otorrhea	☐ Tinnitus	☐ Sore Throat
HEART:	☐ Chest pain	☐Palpitations	☐ Slow Heart rate	☐ Tachycardia (fast Heart rate)	
RESPIRATORY:	☐ Difficulty Breathing	☐Shortness of breath	☐ Coughing	☐ Wheezing	
GI:	☐ Decreased Appetite	☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Diarrhea
GU:	☐ Frequent urination	☐Urinary urgency	☐ Urinary incontinence		
ENDOCRINE:	☐Heat Intolerance	☐ cold intolerance	☐ Feelings of weakness		
MUSCLE:	☐ Neck pain	☐ Back Pain	☐ Muscle Aches	☐ Joint Pain	☐ Muscle cramps
	☐ Joint pain	☐ Joint Swelling	☐ Joint Stiffness		
NEUROLOGY	☐ Dizziness	☐ Vertigo	☐ Fainting	☐ weakness ☐ Tingling	☐ Numbness
PSCH:	☐ Anxiety	☐Depression	☐ Memory loss		
SKIN:	☐ Dry Skin	☐ itching	☐ peeling of skin	☐ Skin Discoloration	☐ Rash

PAIN ASSESMENT FORM

Draw the location of your pain on the figures below.

For Symptoms of pain, fill in the affected area with the following pattern: xxxxxxxxxx

For symptoms of numbness and or tingling, fill in the affected area with the following pattern: ooooooooooo



I attest that the information provided above is true to my knowledge.

Patient/Authorized Signature______________________________ Date_____________

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