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) OCCUPATION: _____

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

UPPER EXTREMITY			LOWER EXTREMITY			NATURE OF VISIT
ARM	☐ R	☐ L	ANKLE/FOOT	☐ R	☐ L	☐ PAIN
ELBOW	☐ R	☐ L	HIP	☐ R	☐ L	☐ FRACTURE
FOREARM	☐ R	☐ L	KNEE	☐ R	☐ L	☐ POST SURGERY.
HAND	☐ R	☐ L	LOWER LEG	☐ R	☐ L	Date _____
SHOULDER	☐ R	☐ L	THIGH	☐ R	☐ L	☐ FOLLOW UP
WRIST	☐ R	☐ L	TOES	☐ R	☐ L	☐ DATE OF ONSET_____

PAIN SEVERITY	PAIN ASSOCIATED WITH		PAIN DESCRIBED AS	
_____/10 (0 no pain) (10 severe pain)	☐Numbness	☐Tingling	☐Aching/Dull	☐Numbing
Have you had a previous history of this injury/condition: ☐ No	☐Muscle spasm	☐Weakness	☐Shooting	☐Stabbing
☐Yes:	☐Popping	☐Instability	☐Sharp	☐Tender
please explain_____	☐Fever	☐Swelling	☐Burning	☐Nagging
	☐ Other _____		☐Tiring	☐Throbbing

What treatments have you already received for this condition?
☐ Medications (list)_____
☐Physical Therapist (how many weeks?) _____ ☐Chiropractor (how long) _____
☐Steroid Injections: How Many injections? _____ When was the last Injection_____
☐ (Please list) Other_____

Since the pain/condition began it:	What aggravates the pain?		What makes the pain better?	
☐ Has improved	☐ Walking	☐ Sitting	☐ Standing	☐ Sitting
☐Has worsened	☐ Standing	☐ Lying down	☐ Lying down	☐ Medications
☐ Has stayed the same	☐ Activity in general		☐ Nothing in particular	
☐ Fluctuates(comes and goes)	☐ Stooping/bending Sharp		☐ Ice or heating pad	
	☐ Nothing in particular		☐ Relaxation techniques	
	☐ Other_____		☐ Other_____	

Timing of Pain			Does the pain awaken you from sleep?
☐ Acute onset	☐ Occasional	☐ Recurrent	☐ Never ☐Occasional ☐Frequently
☐ Chronic	☐ Rare	☐ Night	Does the pain keep you from sleep?
☐ Daytime	☐ Intermittent	☐ Morning	☐ Never ☐Occasional ☐Frequently

HOUSTON SPINE INSTITUTE

Name: _____
Date: _____

PATIENT QUESTIONAIRE FORMS

PAST MEDICAL/SURGICAL HISTORY

Do you have any of this medical conditions?

☐Diabetes ☐High blood pressure ☐Heart disease ☐Cancer/tumor ☐Ulcers
☐ Lung disease ☐ Circulation problems ☐High Cholesterol ☐Liver disease ☐Stroke
☐ Kidney disease ☐Hepatitis ☐Immune Disorder ☐ Seizure ☐Asthma
☐ Thyroid Disorder ☐Headaches ☐Osteoarthritis ☐Eye problems
☐Mental Disorder ☐Rheumatoid Arthritis ☐Other _____

Please previous surgeries:

Date	Place	Surgeon	Procedure

CURRENT MEDICATIONS:

Name	Dose	for what problem?

ALLERGIES:

☐ No known Drug Allergies? Including iodine/contrast dye or shellfish
☐ Yes, Please List _____

SOCIAL AND FAMILY HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
How many Children do you have? _____
What is the highest level of education you have completed?
☐Some high School ☐High School ☐Trade School ☐College ☐Professional School
Do you smoke ☐No ☐Yes: packs per day _____?
Do you smoke pipe ☐No ☐Yes: how often? _____
Do you drink alcohol ☐ Frequently ☐ Occasionally ☐ Everyday

FAMILY HISTORY: Do you have any family history of any of these diseases? (Check all that are appropriate)
☐None ☐ neck or back problems ☐Diabetes ☐High blood pressure ☐Heart ☐Disease ☐Stroke
☐Rheumatoid Arthritis ☐Cancer ☐Osteoarthritis ☐Scoliosis ☐Other _____

REVIEW OF SYSTEMS (check all that appropriate)

GENERAL: ☐ Weight gain ☐Weight loss ☐fever ☐ chills ☐night sweats
SKIN: ☐ Changes in Mole ☐Breast Lumps
EYES: ☐ Loss of vision ☐Double vision
ENT: ☐ Hearing loss ☐Nose bleeds
GI: ☐ Nausea ☐Vomiting ☐Heartburn ☐ change in bowel habits
RESPIRATORY: ☐ Coughing/Wheezing ☐Shortness of breath
HEART: ☐ Chest pain ☐Palpitations ☐ fainting
GU: ☐ Frequent urination ☐Blood in urine ☐Difficulty with Urination
VASCULAR: ☐ Swelling in legs ☐Blood clots
MUSCLE: ☐ Muscle weakness ☐Stiffness ☐ Joint pain
PSCH: ☐ Anxiety ☐Depression ☐ Confusion ☐ Memory loss