

TOWN AND COUNTRY CROSSING ORTHOPEDICS

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SPINE PATIENT QUESTIONNAIRE (Cervical Attachment)

 Please answer all questions completely

 It is in your best interest and will assist Dr. Taylor with your care.

Please be aware that Dr. Taylor, orders, directs, and refers patients for treatment, testing, therapy, and/or rehabilitation at facilities in which he has a financial interest. These financial interests include partial ownership in facilities which perform imaging tests, provide DME services, and surgical centers.

Facilities: CT Partners of Chesterfield, MRI Partners of Chesterfield, Imaging Partners of Missouri, Pain and Rehabilitation Specialists of St. Louis, St. Louis Spine and Orthopedic Surgery Center.

You as a patient or employer of a patient have the right to refuse care at these facilities. To all insurers, please notify any repricer you choose of Dr. Taylor's Disclosure provided in this document.

NAME: _____ DATE: _____

BIRTHDATE: _____ / _____ / _____ HEIGHT: _____ FT. _____ IN. WEIGHT _____ LBS

A. 1. Referring doctor name and full address: _____

If not referred, how did you choose this office? _____

2. Internist or family doctor name and address: _____

3. Chief complaint Neck pain Arm: Pain Numbness Weakness
(check all that apply): Back pain Leg: Pain Numbness Weakness Other _____

4. Your age: _____ Years _____ Months

5. Your sex: Male Female

6. How long has the pain (or your problem) been present? _____

7. Has your problem worsened recently? No Yes – How recently? _____

8. What started the pain (or problem)? _____

B. For patients with NECK OR ARM pain, numbness or weakness:

(If you are seeing the doctor for back or leg pain, go to "C")

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

- Neck 0%, Arm 100% Neck 10%, Arm 90% Neck 25%, Arm 75% Neck 40%, Arm 60%
 Neck 50%, Arm 50% Neck 60%, Arm 40% Neck 75%, Arm 25% Neck 90%, Arm 10%
 Neck 100%, Arm 0%

2. There is: No arm pain Arm pain is as follows (check the following):

- a. Right 0%, Left 100% Right 10%, Left 90% Right 25%, Left 75% Right 40%, Left 60%
 Right 50%, Left 50% Right 60%, Left 40% Right 75%, Left 25% Right 90%, Left 10%
 Right 100%, Left 0%

b. The arm pain is present in the (check the following):

- Right:** Upper back Shoulder Upper arm Forearm Hand/finger
Left: Upper back Shoulder Upper arm Forearm Hand/finger

3. Raising the arm: Improves the pain Worsens the pain Does not affect the pain

4. Moving the neck: Improves the pain Worsens the pain Does not affect the pain

5. There is: No weakness of the arms and hands Weakness of the (check the following):

- Right:** Shoulder Upper arm Forearm Hand/finger
Left: Shoulder Upper arm Forearm Hand/finger

6. There is: No numbness of the arms and hands Numbness of the (check the following):

- Right:** Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger
Left: Upper arm Forearm Thumb Index finger Long finger Ring finger Small finger

7. There (is is no) difficulty picking up small objects like coins or buttoning buttons.

8. There (is a is no) problem with balance or tripping frequently.

9. There are: (Frequent Occasional No) headaches in the back of the head.

END OF NECK QUESTIONS – PLEASE GO TO "D"

Patients Signature

Date

C. For patients with BACK OR LEG PAIN, numbness or weakness.

(If you are seeing the doctor for neck problems, please complete section "B")

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):

<input type="checkbox"/> Back 0%, Leg 100%	<input type="checkbox"/> Back 10%, Leg 90%	<input type="checkbox"/> Back 25%, Leg 75%	<input type="checkbox"/> Back 40%, Leg 60%
<input type="checkbox"/> Back 50%, Leg 50%	<input type="checkbox"/> Back 60%, Leg 40%	<input type="checkbox"/> Back 75%, Leg 25%	<input type="checkbox"/> Back 90%, Leg 10%
<input type="checkbox"/> Back 100%, Leg 0%			
2. There is: No leg pain Leg pain as follows (check the following):
 - a. Right 0%, Left 100% Right 10%, Left 90% Right 25%, Left 75% Right 40%, Left 60%
 - Right 50%, Left 50% Right 60%, Left 40% Right 75%, Left 25% Right 90%, Left 10%
 - Right 100%, Left 0%
 - b. The pain is present in the (check the following):

Right:	<input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left:	<input type="checkbox"/> Buttock	<input type="checkbox"/> Thigh-front	<input type="checkbox"/> Thigh-back	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
3. There is: No weakness of the legs Weakness of the (check the following):

Right:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
Left:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot	<input type="checkbox"/> Big toe
4. There is: No numbness of the legs Numbness of the (check the following):

Right:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
Left:	<input type="checkbox"/> Thigh	<input type="checkbox"/> Calf	<input type="checkbox"/> Foot
5. The worst position for the pain is: Sitting Standing Walking
6. How many minutes can you stand in one place without pain? 0-10 15-30 30-60 60+
7. How many minutes can you walk without pain? 0-10 15-30 30-60 60+
8. Lying down: Eases the pain Does not ease the pain Sometimes eases the pain
9. Bending forward: Increases the pain Decreases the pain Doesn't affect the pain

PLEASE GO TO "D"

D. ★★★ ALL PATIENTS SHOULD ANSWER THE FOLLOWING ★★★

1. Coughing or sneezing (Increases Sometimes increases Does not increase) the pain.
2. There is: No loss of bowel or bladder control Loss of bowel or bladder control since _____
3. I have: Not missed any work because of this problem Missed (how much?) _____ work
4. Treatments have included: No medicines, therapy, manipulations, injections, or braces

Neck Back <input type="checkbox"/> Physical therapy, exercise <input type="checkbox"/> Massage & ultrasound <input type="checkbox"/> Traction <input type="checkbox"/> Manipulation <input type="checkbox"/> Tens Unit <input type="checkbox"/> Shoulder injections <input type="checkbox"/> Braces	Neck Back <input type="checkbox"/> Anti-inflammatory medications <input type="checkbox"/> Narcotic medication <input type="checkbox"/> Epidural steroid injections _____ times which relieved the pain for (how long)? _____ <input type="checkbox"/> Trigger point injections _____ times which relieved the pain for (how long)? _____ <input type="checkbox"/> Other: _____
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5. List pain medications and dose taken for your spine problem: None

Medication	Dose

Patients Signature

Date

6. Previous doctors seen about this problem: None

Doctor	Specialty	City (If not St. Louis)	Treatments

7. Tests done to evaluate your problem, the dates and the location they were done: None

	Neck	Back	#1 DATE	WHERE	#2 DATE	WHERE	#3 DATE	WHERE
Plain x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
EMGs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____

E. REVIEW OF SYSTEMS: Check all that apply. None apply

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Reading glasses | <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Hot or cold spells |
| <input type="checkbox"/> Change of vision | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Recent weight change |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Calf cramps w/ walking | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Nervous exhaustion |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Burning on urination | Women only: |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Toothache | <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Gum trouble | <input type="checkbox"/> Get up more than once every night to urinate | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent spotting |
| <input type="checkbox"/> Morning cough | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Frequent belching | <input type="checkbox"/> Frequent rash | _____ |
| <input type="checkbox"/> Heart or chest pain | <input type="checkbox"/> Frequent diarrhea | | _____ |

F. MEDICAL HISTORY: Check all that apply. None apply

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> AIDS | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Blood clot in leg | <input type="checkbox"/> Serious injuries (explain) |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood clot in lung | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Other: _____ |

G. SURGICAL HISTORY: Previous surgeries - List procedures, surgeon and date. None

OPERATION	SURGEON	DATE

H. FAMILY HISTORY: Check all that apply. None apply

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney trouble or stones | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine problems | <input type="checkbox"/> Bleeding disorders | _____ |

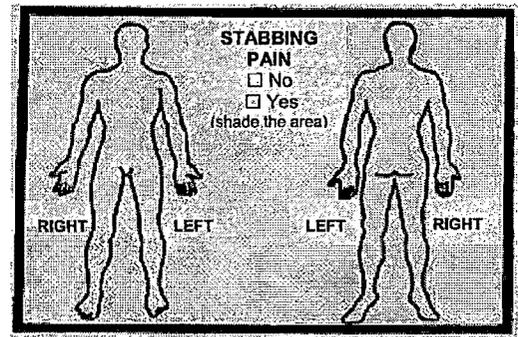
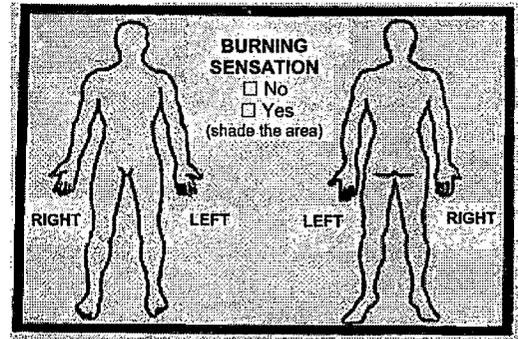
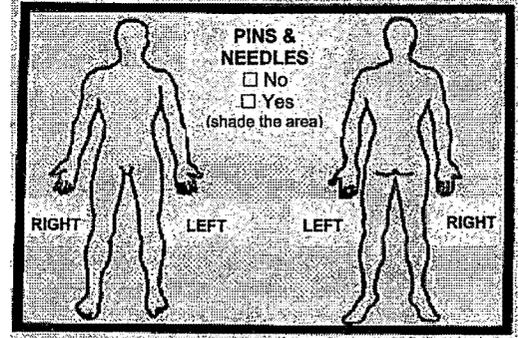
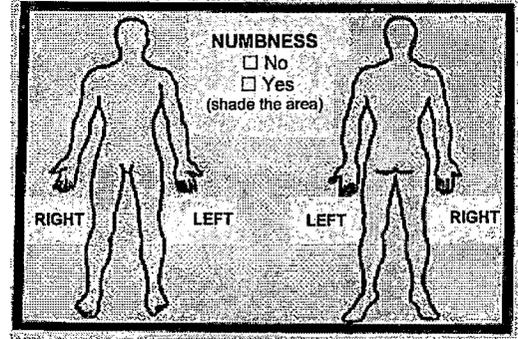
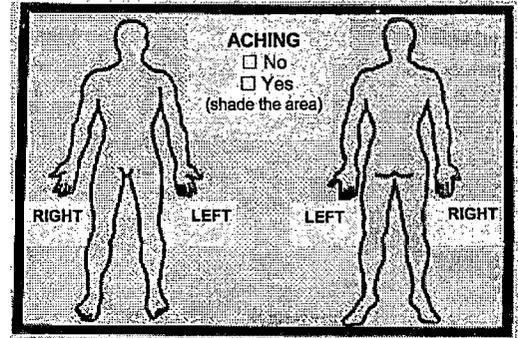
I. MEDICATIONS YOU TAKE: None

Patients Signature

Date

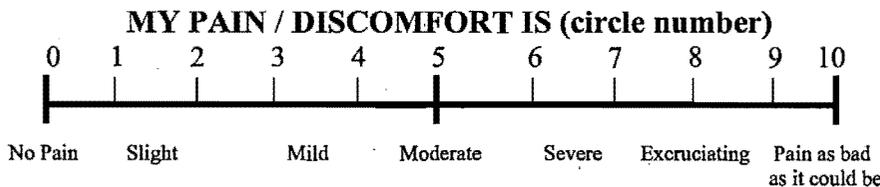
J. ALLERGIES TO MEDICATIONS: No known drug allergies

MEDICATION	Rash	Swelling Wheezing or Shock	Upset Stomach	Unknown Reaction	Other
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



K. SOCIAL HISTORY:

- Work status: Homemaker Retired Disabled On leave
 Unemployed Working: ___ Full time ___ Part time
 Occupation: _____
- Marital status: Married Single Co-habiting
 Widowed Divorced
- Number of living children: 1 2 3 4 5
 6 7 8 9 10
- I live: Alone With: _____
- Tobacco use: Never (skip to #6)
 Cigar Chew Pipe Cigarettes
 _____ packs per day for _____ years.
 Quit – When? _____ after smoking
 _____ packs per day for _____ years (total)
- Alcohol: Never or rare
 Social Frequently drunk (more than twice a week)
 Alcoholic Recovering alcoholic
- Drug overuse/abuse: Never Currently In the past
- Because of this spine problem, I have filed or plan to file:
 A lawsuit A Worker's Compensation claim
 Neither a lawsuit or Worker's Compensation claim



 Patient Signature

 Date

Neck Disability Index

Please read: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

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

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want to with moderate pain in my neck
- I can't read as much as I want because of pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5 – Headaches

- I have no headaches at all
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently
- I have moderate headaches which come frequently
- I have severe headaches which come frequently
- I have headaches almost all the time

Patient Signature _____

Date: ____/____/____

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7 – Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

Section 8 – Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck
- I cannot drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I cannot drive my car at all

Section 9 – Sleeping

- I have no problem sleeping
- My sleep is slightly disturbed (less than 1 hour sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-6 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

Section 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some pain in my neck
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- I am able to engage in few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I cannot do any recreation activities at all

NECK AND ARM PAIN QUESTIONNAIRE

This form is for the purpose of collecting Neck pain and Arm pain information from you. Answer **every** question by filling in the appropriate circle. If you are unsure about how to answer a question, please give the best answer you can. Mark only **one** answer for each question.

NECK PAIN

1. On the scale of 0 to 10, mark your intensity of **neck** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain As Bad As It Could Be
	<input type="radio"/>											

2. On the scale of 0 to 10, mark how often you had **neck** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	All Of The Time
	<input type="radio"/>											

ARM PAIN

1. On the scale of 0 to 10, mark your intensity of **arm** pain discomfort with 0 being **no pain** and 10 being **pain as bad as it could be**.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain As Bad As It Could Be
	<input type="radio"/>											

2. On the scale of 0 to 10, mark how often you had **arm** pain discomfort with 0 being **none of the time** and 10 being **pain all of the time**.

None Of The Time	0	1	2	3	4	5	6	7	8	9	10	All Of The Time
	<input type="radio"/>											

Patients Signature

Date

HISTORY:

1. Is this an unresolved spinal litigation case? Yes No
If yes, please answer the following:
a. Is this the result of a motor vehicle accident? Yes No
b. Is this the result of a personal injury? Yes No
c. Other, please describe: _____
2. How long ago did your **current** back/neck symptoms begin?
 Less than two weeks ago Between two and eight weeks ago
 Between eight and twelve weeks ago Three months to six months ago
 Between six and twelve months ago More than twelve months ago
3. Have you had back/neck symptoms **before** your current episode?
 No Yes, one episode Yes, two or more episodes
4. How much work did you miss because of your worst **prior** episode?
 None 1 day to 2 weeks Between 2 and 4 weeks
 Between 4 and 12 weeks Between 12 and 24 weeks More than 24 weeks
5. Have you had **previous** back/neck surgery?
 No Yes; How many? _____
6. If so, did you return to work?
 No Yes, with limitations Yes, with no limitations
 Never stopped working Did not work prior to surgery
7. Which health care provider(s) have you used for your **current** condition? (Mark all that apply)
 Acupuncturist Chiropractor Emergency Room Internist
 General Practitioner Immediate Care Clinic Massage Therapist Neurosurgeon
 Nurse Practitioner Osteopath Orthopedic Surgeon Pain Clinic
 Physical Therapist Rheumatologist Work Hardening Other: _____
-

PAIN OR MUSCLE RELAXANT MEDICATION REGIMEN

During the last week, how often have you taken the following for your back/leg pain or neck/arm pain:

8. Non-Narcotic medication (such as aspirin, Tylenol, Motrin, Vioxx, Celebrex)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all
9. Weak narcotic medication (such as Tylenol #3, Darvocet N-100, Darvon, Vicodin)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all
10. Strong narcotic medication (such as Percodan, Percocet, Morphine, Demerol)
 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all

Patients Signature

Date

12/14

10. How often do you lift 25 lbs. on job?
 All of the time Most of the time A good bit of the time
 Some of the time A little of the time None of the time
11. How often do you lift 50 lbs. on job?
 All of the time Most of the time A good bit of the time
 Some of the time A little of the time None of the time
12. Is your job physically demanding?
 Extremely Very much Quite a bit Somewhat A little Not at all
13. Is your job stressful?
 Extremely Very much Quite a bit Somewhat A little Not at all
14. How much do you enjoy your job?
 Extremely Very much Quite a bit Somewhat A little Not at all
15. How much do you like your co-workers?
 Extremely Very much Quite a bit Somewhat A little Not at all
16. How much do you like your supervisor?
 Extremely Very much Quite a bit Somewhat A little Not at all
17. Other sources of income (mark all that apply)
 Another income Disability State support
 Other income Social Security No other income
18. Your opinion of fault (mark all that apply)
 Own fault Another fault Employer fault
 Co-worker fault No fault
19. Financial difficulties due to back condition?
 None at all Only a little Some A lot
20. Are you on, or planning to apply for Social Security?
 No Already on it Applied for it Planning to apply
21. Are you on, or planning to apply for Disability?
 No Already on it Applied for it Planning to apply
22. Are you on, or planning to apply for Worker's Compensation?
 No Already on it Applied for it Planning to apply
23. Are you on, or planning to apply for other program?
Other program description _____
 No Already on it Applied for it Planning to apply

Patients Signature

Date

Physician Signature

Date