



TOWN AND COUNTRY CROSSING ORTHOPEDICS

Brett A. Taylor, MD
884 Woods Mill Rd.
Suite 201
St. Louis, Missouri 63011

SPINE QUESTIONNAIRE (Lumbar 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 and testing 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: Town and Country Crossing Orthopedics and 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"

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"/> <input type="checkbox"/> Physical therapy, exercise <input type="checkbox"/> <input type="checkbox"/> Massage & ultrasound <input type="checkbox"/> <input type="checkbox"/> Traction <input type="checkbox"/> <input type="checkbox"/> Manipulation <input type="checkbox"/> <input type="checkbox"/> Tens Unit <input type="checkbox"/> <input type="checkbox"/> Shoulder injections <input type="checkbox"/> <input type="checkbox"/> Braces	Neck Back <input type="checkbox"/> <input type="checkbox"/> Anti-inflammatory medications <input type="checkbox"/> <input type="checkbox"/> Narcotic medication <input type="checkbox"/> <input type="checkbox"/> Epidural steroid injections _____ times which relieved the pain for (how long)? _____ <input type="checkbox"/> <input type="checkbox"/> Trigger point injections _____ times which relieved the pain for (how long)? _____ <input type="checkbox"/> <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.

- Reading glasses
- Change of vision
- Loss of hearing
- Ear pain
- Hoarseness
- Nosebleeds
- Difficulty swallowing
- Morning cough
- Shortness of breath
- Fever or chills
- Heart or chest pain
- Abnormal heartbeat
- Swollen ankles
- Calf cramps w/ walking
- Poor appetite
- Toothache
- Gum trouble
- Nausea or vomiting
- Stomach pain
- Ulcers
- Frequent belching
- Frequent diarrhea
- None apply
- Frequent Constipation
- Hemorrhoids
- Frequent urination
- Burning on urination
- Difficulty starting urination
- Get up more than once every night to urinate
- Frequent headaches
- Blackouts
- Seizures
- Frequent rash
- Hot or cold spells
- Recent weight change
- Nervous exhaustion

Women only:

- Irregular periods
- Vaginal discharge
- Frequent spotting
- Other _____

F. MEDICAL HISTORY: Check all that apply.

- Heart attack
- Heart failure
- High blood pressure
- Osteoarthritis
- Rheumatoid arthritis
- Ankylosing spondylitis
- Gout
- Osteoporosis
- Diabetes
- Stroke
- Seizures
- Mental illness
- Kidney stones
- Kidney failure
- Cancer
- Alcoholism
- None apply
- Lung disease
- HIV
- AIDS
- Tuberculosis
- Asthma
- Blood clot in leg
- Blood clot in lung
- Stomach ulcers
- Liver trouble
- Hepatitis
- Thyroid trouble
- Bleeding disorders
- Anemia
- Serious injuries (explain)
- Other: _____

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

OPERATION	SURGEON	DATE

H. FAMILY HISTORY: Check all that apply.

- Stroke
- Heart trouble
- High blood pressure
- Diabetes
- Arthritis
- Gout
- Seizures
- Spine problems
- None apply
- Mental illness
- Kidney trouble or stones
- Cancer
- Bleeding disorders
- Alcoholism
- Other: _____

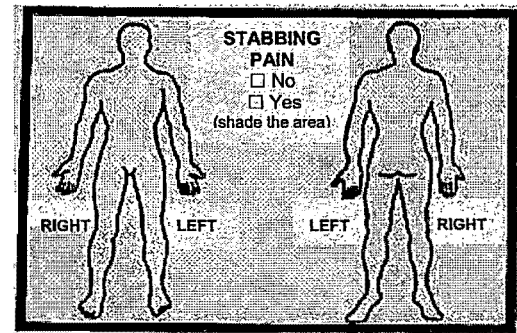
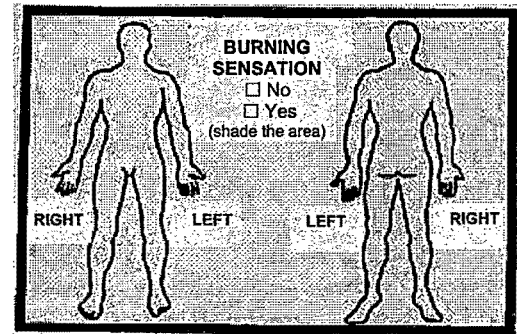
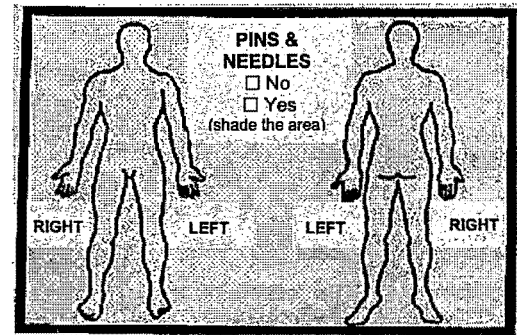
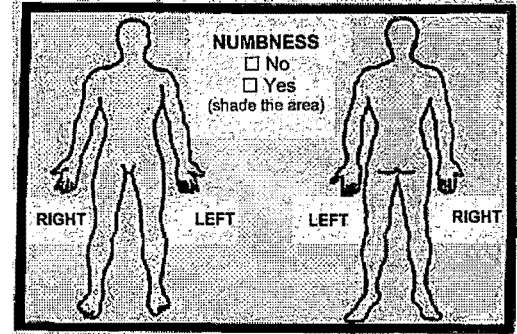
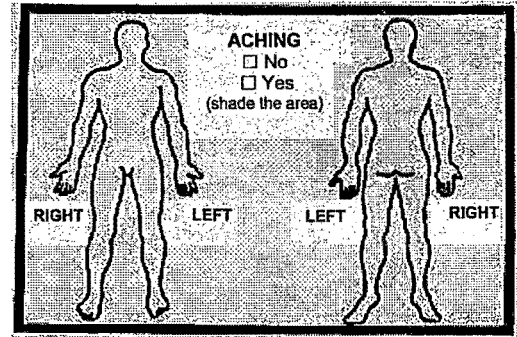
I. MEDICATIONS YOU TAKE: None

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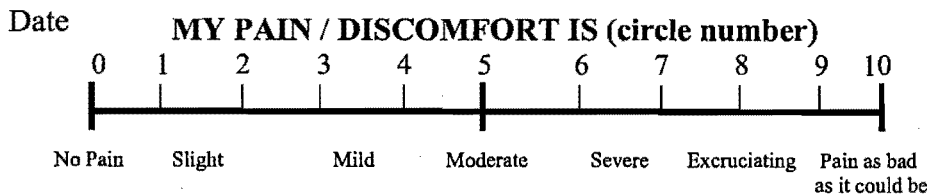
J. ALLERGIES TO MEDICATIONS: No known drug allergies

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"/>	_____



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



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OSWESTRY QUESTIONNAIRE

The following questions will give us information as to how your back or leg pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the answer which applies to you. We realize you may consider that two of the statements in any one section relate to you. Please just give the answer which most clearly describes your problem.

Pain Intensity (mark only one)

0. I have no pain at this moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Personal Care (washing, dressing, etc.) (mark only one)

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

Lifting (mark only one)

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

Walking (mark only one)

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking for more than 1 mile.
2. Pain prevents me from walking for more than 1/4 mile.
3. Pain prevents me from walking for more than 100 yards.
4. I can only walk using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

Sitting (mark only one)

0. I can sit in any chair as long as I like.
1. I can sit in my favorite chair as long as I like.
2. Pain prevents me from sitting for more than 1 hour.
3. Pain prevents me from sitting for more than 1/2 hour.
4. Pain prevents me from sitting for more than 10 minutes.
5. Pain prevents me from sitting at all.

Standing (mark only one)

0. I can stand as long as I want without extra pain.
1. I can stand as long as I want, but it gives me extra pain.
2. Pain prevents me from standing for more than one hour.
3. Pain prevents me from standing for more than 1/2 hour.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Sleeping (mark only one)

0. My sleep is never disturbed by pain.
1. My sleep is occasionally disturbed pain.
2. Because of pain I have less than 6 hours sleep.
3. Because of pain I have less than 4 hours sleep.
4. Because of pain I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

Sex Life (mark only one)

0. My sex life is normal and causes no extra pain.
1. My sex life is normal, but causes some extra pain.
2. My sex life is nearly normal, but is very painful.
3. My sex life is severely restricted by pain.
4. My sex life is nearly absent because of pain.
5. Pain prevents any sex life at all.

Social Life (mark only one)

0. My social life is normal and gives me no extra pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. sports, etc.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have no social life because of pain.

Traveling (mark only one)

0. I can travel anywhere without extra pain.
1. I can travel anywhere, but it gives me extra pain.
2. Pain is bad, but I manage journeys over two hours.
3. Pain restricts me to journeys of less than one hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from traveling except to receive treatment.

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BACK AND LEG PAIN QUESTIONNAIRE

This form is for the purpose of collecting back pain and leg 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.

BACK PAIN

1. On the scale of 0 to 10, mark your intensity of back 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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

2. On the scale of 0 to 10, mark how often you had back 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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

LEG PAIN

1. On the scale of 0 to 10, mark your intensity of leg 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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

2. On the scale of 0 to 10, mark how often you had leg 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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Patients Signature

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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

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11. Muscle Relaxant medication (such as Flexeril, Parafon Forte, Robaxin)

- 3 or more times a day Once or twice a day Once every couple of days
 Once a week Not at all

WORK STATUS:

1. Are you currently working? Yes No
2. If you are currently working, please answer the following:
- a. Occupation: _____
- b. Full Time Part Time
 Full Duty Light Duty
- c. If you are working less than **Full Time** or **Full Duty**, is this because of the problems with your back/neck?
 Yes No
3. If you are not currently working, answer the following:
- a. Are you not working because of problems with your back/neck? Yes No
- b. Retired
- c. Not Currently Employed
4. Highest level of education attained: < High School Associates Degree Masters Degree
 High School Bachelors Degree Professional Degree
5. When did you stop working?
- Less than one week ago
 More than one week but less than three months ago
 More than three months but less than six months ago
 More than six months but less than one year ago
 One to two years ago
 More than two years ago
 Never employed
 Currently working
6. Is your current job the same as when your back/neck problems began?
- Yes, exact same job.
 No, job changed due to back problems.
 Yes, but job was lightened due to back problems.
 No, job changed for reasons other than back.
 Not currently working.
7. How long have you been at current job?
- Less than six months Six to 12 months More than 12 months Not currently working
8. How much sitting does your job involve?
- 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
9. How much standing/walking does your job involve?
- 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

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

10/10

Patients Signature

Date

Physician Signature

Date