UT Southwestern Medical Center

Spine Clinic

New Patient Questionnaire

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

In order to provide you with the most effective medical care, the providers of the Spine Clinic need certain basic information about your medical, family, and social history. Please take the time to complete this questionnaire and bring it with you to your evaluation appointment. Your responses to these questions will assist the doctors in their evaluations and is an important contribution to your overall care.

BASIC PATIENT INFORMATION

Why are you seeking an evaluation at this time (Chief Complaint): _____

_____

_____

When did this problem start? _____

Is your injury work related? ☐ No ☐ Yes If yes, date of injury: _____

Since your pain started, has it? ☐ Gotten better ☐ Worsened ☐ Not changed ☐ Varied ☐ Not applicable

Hand Dominance? ☐ Right ☐ Left ☐ Ambidextrous

How do the following activities affect your pain?

	Better	Worse	Unchanged
Lifting			
Bending			
Twisting			
Sitting			
Standing			
Walking			
Lying down			
Activity in general			
Nothing in particular			

What have you tried for your condition?

	Yes	No	Duration	Helpful
Physical therapy				
Injections				
Rest				
Medications				
Chiropractic treatment				
Manipulation				
Exercise				
Traction				
Heat / Cold				
TENS				
Acupuncture				
Surgery				
Other:				

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PAST SPINE SURGICAL HISTORY

Surgical history: Have you had spine related surgery? ☐ No ☐ Yes

If YES, please complete the following:

Date	Type of Surgery / Reason for Surgery	Name of Hospital / Location

SOCIAL HISTORY

Are you married, single, divorced, or widowed? _____

Do you live alone? ☐ Yes ☐ No If no, with whom do you live? _____

How many grades did you complete in school? _____

Are you presently employed? ☐ Yes ☐ No If no, was it due to illness or retirement? _____

What is/was your primary occupation? _____

When did this retirement / disability start? _____

Do you exercise regularly? ☐ No ☐ Yes

Do you use any assistive devices (walker, cane, wheelchair, etc.) ☐ No ☐ Yes If yes, specify: _____

Do you drink beer, wine, or liquor? ☐ No ☐ Yes

Do you use recreational drugs? ☐ No ☐ Yes (If Yes, please explain)

_____

_____

_____

UT Southwestern
Medical Center

Spine Center

Pain Scale Evaluation

Pt. Name:_____

Address:_____

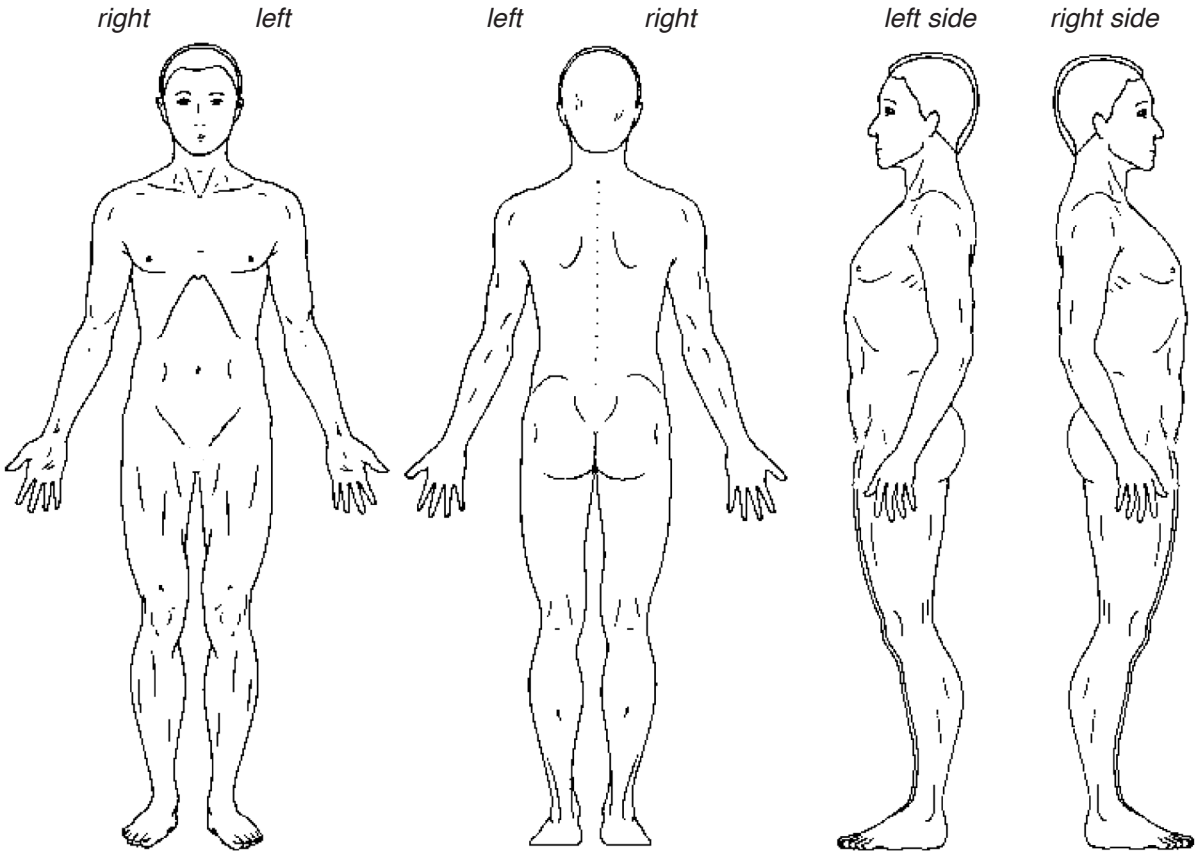
_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

On this drawing, please mark the places where you feel pain.



On these scales, rate your pain by placing an X on the lines. Zero (0) is *no* pain. Ten (10) is the *worst* pain that *you could ever imagine*. Five (5) is halfway in between these extremes. *Pain cannot be greater than 10.*

Pain right now:

0 5 10

Average pain this past week:

0 5 10

Pain when it is at its worst:

0 5 10

Pain when it is at its best:

0 5 10

My pain is (mark all that apply):

- ☐ sharp
- ☐ dull
- ☐ aching
- ☐ burning
- ☐ other _____