PID_____ Date_____ Physician_____

TOCA SPINE SERVICE
NEW PATIENT QUESTIONAIRE

Name:_____Age:_____Date of Birth:_____

Who referred you to our office?:_____

What problem do you have with your neck or back?:_____
_____

When did your problem start?:_____

Instructions: Only complete sections A-G below, that apply to you (the body figures you will have to mark when you get to the office, you will not be able to mark them online). There will be a General Medical section that will need to be completed in full and starts on page 5.

INJURY OR TRAUMA (SECTION A)

Did a particular accident or injury cause your problem?

- ☐ No (please skip to Section B
- ☐ Yes (continue this section)

Check only one below:

- ☐ I never had back/neck problems in this area of my spine before this injury.
- ☐ I had back/neck problems in this area of my spine before, and this injury made the problem worse.

Check all that apply below:

- ☐ This injury occurred at work.
- ☐ This injury did not occur at work.
- ☐ I have filed a claim through workers compensation.

DO NOT WRITE BELOW THIS LINE. (Turn over for page 2)_____

HT_____
WT_____
BP_____
P_____
R_____

_____FILMS

PCP_____

REFERRED BY_____

PID_____ Date_____ Physician_____

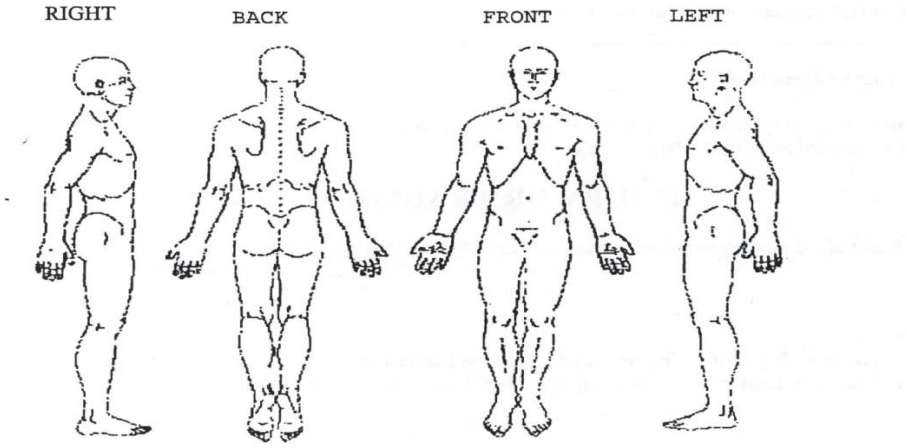
PAIN AND DISABILITY (SECTION B)

This section pertains to **pain** only. You will have an opportunity to answer questions about numbness and tingling in **Section C**.

Does your neck or back problem cause pain?

☐ No (please **skip to section C**)
☐ Yes (continue this section)

Mark your **pain** on the figures below: ***If you are filling this out online***, you will not be able to mark the body part pictures. You will be able to complete those marks in the office.



Pain scale 0-10 (0 = No pain, 10 = pain severe enough to pass out)

What number would you give your pain today?_____
What number would you give your pain on average?_____
What number would you give your pain at its worst?_____

Please check all that describe your pain:

☐ Burning ☐ Sharp/Stabbing ☐ Tingling ☐ Aching ☐ Throbbing
☐ Shooting ☐ Pulling/Tearing ☐ Cramping ☐ Other:_____

Please check all of the appropriate responses in each category to complete the phrase:

My pain……

☐ began suddenly ☐ began gradually ☐ interrupts my sleep
☐ is constant ☐ comes and goes

My pain is worse……..

☐ during the day ☐ at night ☐ in the AM ☐ in the afternoon

My pain is worse when……..

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Driving
☐ Applying heat ☐ Applying ice ☐ Exercising ☐ Frequently changing positions ☐ Lying
☐ Sports (list)_____ ☐ Overhead activity ☐ Other (describe)_____
☐ Nothing makes my pain worse

My pain is better while……..

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Driving
☐ Applying heat ☐ Applying ice ☐ Exercising ☐ Frequently changing positions ☐ Lying
☐ Sports (list)_____ ☐ Overhead activity ☐ Other (describe)_____
☐ Lying on back ☐ Lying on side ☐ Lying on stomach ☐ Recliner
☐ Nothing makes my pain better

PID_____ Date_____ Physician_____

Overall, which single word or phrase would you use to describe your pain the majority of the time?

☐ Trivial/minimally annoying ☐ Limiting ☐ Disabling ☐ Unbearable

Because of my pain, I am unable to……..

☐ Walk over_____miles ☐ Run over _____miles ☐ Sit longer than _____min/hrs
☐ Stand longer than _____min/hrs ☐ Lift over _____lbs

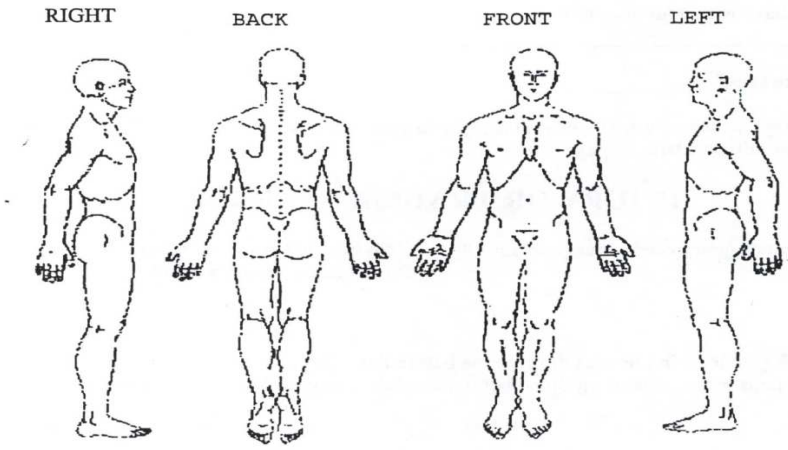
NUMBNESS/TINGLING (Section C)

This section pertains to numbness/tingling **only**. Questions about pain are in the previous section (**section B**).

Do you feel numbness or tingling?

☐ No (please **skip to section D**)
☐ Yes (continue this section)

Please mark on the figure below to show where you feel **numbness (loss of feeling) or tingling (pins and needles).** ***If you are filling this out online***, you will not be able to mark the body part pictures. You will be able to complete those marks in the office.



My numbness and tingling is made worse while……..

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Driving
☐ Heat ☐ Ice ☐ Exercising ☐ Frequent change of position
☐ Sports (list)_____ ☐ Other (describe)_____
☐ Nothing makes my numbness/tingling worse

My numbness and tingling is made better while……..

☐ Walking ☐ Running ☐ Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Driving
☐ Heat ☐ Ice ☐ Exercising ☐ Frequent change of position
☐ Sports (list)_____ ☐ Other (describe)_____
☐ Nothing makes my number/tingling better

PID_____ Date_____ Physician_____

SPINAL DEFORMITY / TUMOR (Section D)

Do you have a curve, lump, or mass near or on your spine?

- ☐ No (please **skip to section E**)
- ☐ Yes (complete this section)

Please check all that apply to your situation.

- ☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **was present at birth.**
- ☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed in childhood**, and was not present or obvious at birth.
- ☐ I have a spinal curvature or deformity (scoliosis or kyphosis) that **developed as an adult**, and was not present in childhood.
- ☐ I wore a brace when I was younger to help my scoliosis or kyphosis.
- ☐ I am wearing a brace now.
- ☐ I have noticed my spinal curvature getting worse.
- ☐ My clothes no longer fit or hang properly.

- ☐ I have a lump or mass on my spine that is **getting larger**.
- ☐ I have a lump or mass on my spine that is **not getting larger**.
- ☐ The mass is painful.
- ☐ The mass is **not** painful.

ASSOCIATED PROBLEMS (Section E)

Please check all that apply to you:

- ☐ **I HAVE NONE OF THE FOLLOWING PROBLEMS**
- ☐ Clumsiness in hands
- ☐ Must look at feet in order to walk
- ☐ Leakage of bowel contents or staining underwear
- ☐ Unable to completely empty your bladder
- ☐ Unable to look forward without bending knees
- ☐ Frequent falling or stumbling
- ☐ Unable to stand up straight
- ☐ Leakage of urine or staining underwear
- ☐ Impotence

TESTING AND TREATMENT (Section F)

Which of the following tests have you had in the last year for your spine problem? (check all that apply)

- ☐ X-rays ☐ Blood test ☐ Myelogram ☐ MRI ☐ CT (CAT Scan)
- ☐ Discogram ☐ Bone Density scan ☐ Nuclear Bone Scan ☐ Never study (EMG/NCS)
- ☐ Other_____
- ☐ **I HAVE HAD NO TESTS TO EVALUATE MY PROBLEM**

Your treatment history (Please check all that apply)

		Complete relief	Improved	Unchanged	Worse
☐	Physical therapy				
☐	Home exercises				
☐	Chiropractic				
☐	Epidural Steroid Injection (performed in the hospital)				
☐	Facet Joint Injection (performed in the hospital)				
☐	Local or Trigger point injection (performed in the office)				
☐	Massage				
☐	Brace, corset, or other support				
☐	Acupuncture				
☐	Other _____				
☐	**I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS**				

PID_____ Date_____ Physician_____

Please list all medications you have tried, the does, and the number of pills used per day for this problem (**examples are** naproxen, Voltaren, ibuprofen, Vicodin, Percocet, OxyContin, morphine, soma, flexeril, robaxin, baclofen, Celebrex, vioxx, bextra, etc.)

When last used?	Medication	Dose	Number of pills per day	Did the medication help?
mm/yy	Example: Motrin	800mg	4	Very helpful

PRIOR SPINE SURGERY (Section G)

Have you ever had surgery on your spine?
(This includes Fusions, decompressions, or any disc procedures)

☐ No (please **skip to medical history, separate form**)
☐ Yes (complete this section)

Date	Procedure	Rate the outcome of surgery: Poor, good or excellent (see legend below)

Legend: Poor = the surgery had no change or made me worse
Good = the surgery improved my symptoms
Excellent = dramatically improved or resolved my symptoms

☐ I have not, nor do I plan to take legal action related to this injury.
☐ I am considering or have taken legal action as a result of this injury.
☐ Legal action related to this injury is closed or settled.

Thank you for completing this questionnaire. This will be incorporated in your initial evaluation.

THE END