SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Today's Date: _____

Please clearly mark the check boxes and fill in the blanks where indicated. Your accurate responses will give us a better understanding of you and your symptoms so that we can provide you with the best care possible. Thank you for your cooperation!

Full Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Hand Preference (Please Circle One): Right / Left / Both

Primary Care Physician: _____ Referring Physician: _____

HISTORY

Please choose priority pain area: ☐ Neck ☐ Low Back Pain ☐ Other: _____

How long have you had this pain? ☐ 0-3 Months ☐ 4-12 Months ☐ 1 Year or More

Does the pain radiate into extremities? (Please Circle Pain Side)

☐ Arms (Left/Right/Both) ☐ Buttocks (Left/Right/Both) ☐ Legs (Left/Right/Both) ☐ Other: _____ (Left/Right/Both)

Do you feel any of the following? If so, please list where on your body.

☐ Weakness: _____ ☐ Tingling: _____

☐ Numbness: _____

Any other symptoms with the pain?

☐ Loss of Bladder Control ☐ Loss of Bowel Control ☐ Headaches ☐ Other: _____

How severe is your pain (mark below)?

☐	☐	☐	☐	☐	☐
0 ABSENT (No Pain)	**1-2 TOLERABLE** (Tolerate Without Medication)	**3-4 BEARABLE** (Some Activities Restricted/ Prevented, Requires Medication)	**5-6 NEARLY INTOLERABLE** (Sedentary, Only Able To Watch TV, Read, Etc.)	**7-8 INTOLERABLE** (Can't Read, Watch TV, Use The Phone, Need To Visit ER For Pain Killers)	**9-10 DEVASTATING** (Need Hospitalization For Pain Control)

Did anything specific happen to cause the pain? ☐ Yes ☐ No

If yes, please describe: _____

SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

PLEASE NOTE: SPINE TEAM TEXAS DOES NOT ACCEPT WORKER'S COMP.

Is the injury or pain motor vehicle related? ☐ Yes ☐ No Date of injury? _____

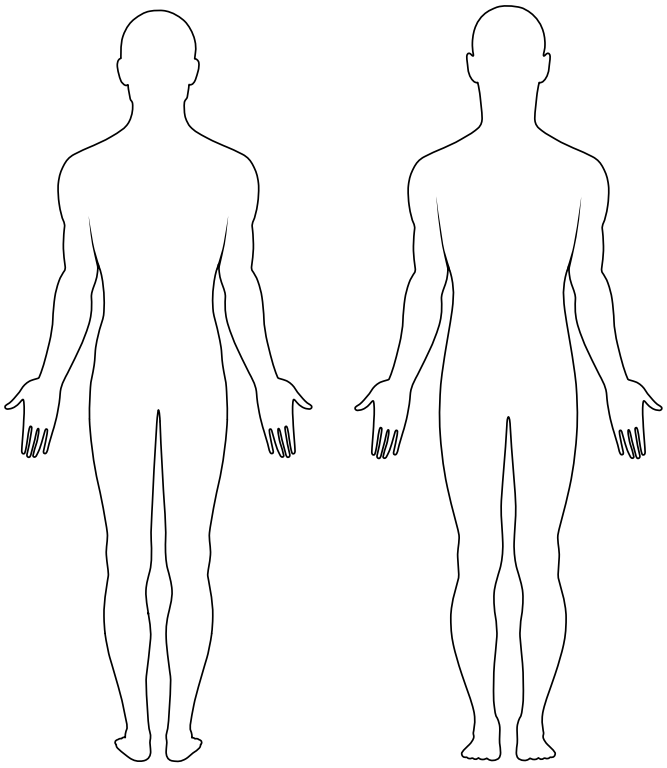
Is there a lawsuit (pending or considered)? ☐ Yes ☐ No

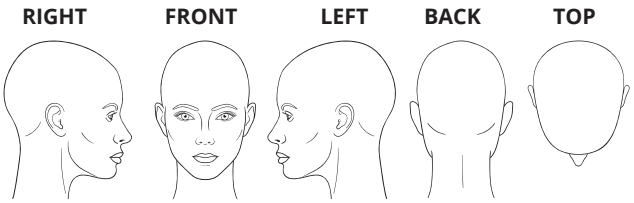
Have you had any of the following treatments for your current condition?

Other Clinicians ☐ Yes ☐ No Name, Date, and Treatment: _____
Physical Therapy ☐ Yes ☐ No # of Sessions: ___ ☐ Better ☐ Worse ☐ No Change
Epidural or Facet Injections ☐ Yes ☐ No # of Injections: ___ ☐ Better ☐ Worse ☐ No Change
Back or Neck Surgery ☐ Yes ☐ No Date and Type: _____
Diagnostic Tests ☐ Yes ☐ No ☐ CT ☐ MRI ☐ EMG ☐ Other: _____

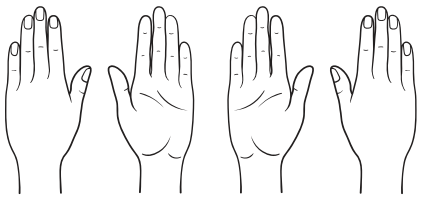
Please mark the location of your symptoms using the key symbols on the figure below:

KEY: Pain= XX Numbness/Tingling= OO Stabbing= // Burning= ++

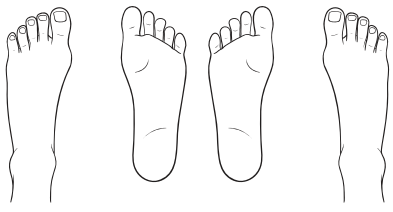




HEAD



LEFT HAND RIGHT HAND



LEFT FOOT RIGHT FOOT

What do you hope we can accomplish today?

_____

SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

Illness/Condition:	Please Check All That Apply (Even If Controlled):		
☐ Alcoholism	☐ Gout	☐ Liver Disease/Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Heart Murmur	☐ Lung Disease	☐ Rheumatoid Arthritis
☐ Anxiety	☐ High Blood Pressure	☐ Migraines	☐ Seizure Disorder
☐ Arthritis	☐ High Cholesterol	☐ MRSA	☐ Sleep Apnea
☐ Asthma	☐ History of Addiction	☐ Muscle Disease	☐ Stroke
☐ Bleeding Disorder	☐ History of Substance	☐ Osteoporosis	☐ Thyroid Disorder
☐ Deep Vein Thrombosis	☐ HIV/AIDS	☐ Pneumonia	☐ Tuberculosis
☐ Depression	☐ Hyperthyroidism	☐ Psoriasis	☐ Ulcers
☐ Diabetes ☐ Type 1 ☐ Type 2	☐ Hypothyroidism	☐ Psychiatric Problem	☐ Other (Please Explain): _____ _____
☐ GERD	☐ Kidney Disease	☐ Pulmonary Embolism	

☐ **Patient Cancer History Box:** Please write what kind of cancer you have and when you had it.
_____

PAST SURGICAL HISTORY

Please list any previous surgeries: ☐ No Surgeries ☐ See Attached

_____ Approximate Date: _____
_____ Approximate Date: _____
_____ Approximate Date: _____

MEDICATIONS

Please list all medications you are currently taking. (Include any over the counter medications and supplements. Be sure to list if you are taking any form of blood thinning medication, including aspirin.)

☐ No Medication ☐ Weight Loss Injectable/Weight Loss Oral Medication ☐ See Attached

_____ _____ _____
_____ Dose: _____ Frequency: _____
_____ Dose: _____ Frequency: _____
_____ Dose: _____ Frequency: _____

SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

List medications that you have taken in the past and indicate if they were effective (including over the counter medication):

_____ Did the medication help? ☐ Yes ☐ No How long did you take it? _____

_____ Did the medication help? ☐ Yes ☐ No How long did you take it? _____

Medication allergies? ☐ Yes ☐ No

Please list: _____

Allergy Reaction: _____

Do you have any other known allergies to the following?

☐ Latex ☐ Tape OR Adhesive ☐ Shellfish ☐ Iodine

PHARMACY INFORMATION

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Number of Children: _____ Ages: _____

Do you use any of the following? Check and fill in all that apply:

☐ Previous Smoker How much? _____ How long? _____	☐ Non-Tobacco Inhalants How much? _____ How long? _____
☐ Current Smoker How much? _____ How long? _____	☐ Drink Alcohol How many drinks per day? _____
☐ Smokeless Tobacco How much? _____ How long? _____	☐ Recreational Drugs Which type? _____
☐ Vape or E-Cigarettes How much? _____ How long? _____	☐ History of alcohol/drug abuse Explain: _____

Occupation: _____

SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS

Please mark an "X" for Yes or mark "I have none of the symptoms listed above" if you have these symptoms TODAY.

SKIN
- ☐ Rashes
- ☐ Infections
- ☐ I have none of the symptoms listed above

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Swelling
- ☐ I have none of the symptoms listed above

RESPIRATORY
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sputum Production
- ☐ Recent Infection
- ☐ I have none of the symptoms listed above

MUSCULOSKELETAL
- ☐ Joint Swelling
- ☐ Stiffness
- ☐ Cramping
- ☐ Infection
- ☐ I have none of the symptoms listed above

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Mood Changes
- ☐ I have none of the symptoms listed above