Banner Health®

FOLLOW-UP QUESTIONNAIRE - SPINE

Patient Name: _____ DOB: _____ Age: _____

E-Mail _____ Height: _____ Weight: _____

Reason for Visit:

PRESENT MEDICAL INFORMATION

What body part is involved? (Please check all that apply below)

Neck:	❑	Arm:	❑ R	❑ L	Shoulder:	❑ R	❑ L
Back:	❑	Leg:	❑ R	❑ L	Knee:	❑ R	❑ L
Face/Head:	❑	Hip:	❑ R	❑ L	Other: _____		

How would you describe the pain?

❑ Dull / Aching ❑ Sharp/Stabbing ❑ Throbbing ❑ Tightness ❑ Burning

❑ Other: _____

How often does the pain occur?

❑ Changes in severity but always present ❑ Intermittent (comes and goes, sometimes no pain)

My pain symptoms are:

❑ Improving ❑ Getting worse ❑ Unchanged

Since your last visit, have you:

Been prescribed any new medications?	❑ No	❑ Yes, describe: _____
Received opioids/narcotics from another physician?	❑ No	❑ Yes, describe: _____
Been hospitalized or gone to the emergency room?	❑ No	❑ Yes, describe: _____
Developed any new allergies?	❑ No	❑ Yes, describe: _____

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PAIN LEVEL – Numerical Rating Scale (0 to 10)

Current pain level:	***No Pain-***	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10 ***-Worst***
Lowest level in past week:	***No Pain-***	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10 ***-Worst***
Worst level in past week:	***No Pain-***	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10 ***-Worst***

ACTIONS AFFECTING PAIN LEVEL

*If you have **BACK** pain, please address the following activities (otherwise, skip this section):*

	WORSE	BETTER	NO EFFECT	REMARKS
Bending forward	❑	❑	❑	_____
Leaning back	❑	❑	❑	_____
Sitting	❑	❑	❑	_____
Standing	❑	❑	❑	_____
Walking	❑	❑	❑	_____
Activity	❑	❑	❑	_____
Rest	❑	❑	❑	_____
Lying flat	❑	❑	❑	_____
Lying with hips and knees bent	❑	❑	❑	_____
Rising out of bed/chair	❑	❑	❑	_____
Coughing/Sneezing	❑	❑	❑	_____

Other: _____

Which of these activities is the most bothersome? _____

What helps the most to improve your pain? _____

ASSOCIATED SYMPTOMS

Do you have any of the following symptoms? And, if so, please describe:

	YES	NO	REMARKS
Numbness / tingling	❑	❑	Where? _____
Weakness in the arm or leg	❑	❑	Describe: _____
Bladder incontinence	❑	❑	If yes, is this a change from previously? ❑ Yes ❑ No
Bowel incontinence	❑	❑	If yes, is this a change from previously? ❑ Yes ❑ No
Numbness in the buttocks	❑	❑	_____
Morning stiffness in joints	❑	❑	How many hours? _____ Which joints? _____
Fever / chills	❑	❑	_____
Sleep interrupted by pain	❑	❑	_____
Joint swelling	❑	❑	Which joints? _____
Headaches	❑	❑	_____
Vision problems	❑	❑	Explain: _____

Activities or hobbies limited due to pain: _____

Do you exercise on a regular basis? ❑ Yes ❑ No How often? _____ times per week Type of exercise: _____

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REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

General

Loss of Appetite	❑ Yes	❑ No
Recent Weight Loss	❑ Yes	❑ No

Respiratory

Shortness of Breath	❑ Yes	❑ No
Chronic Cough	❑ Yes	❑ No

Kidney/Bladder/Urine

Painful Urination	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No

Gastrointestinal

Nausea or Vomiting	❑ Yes	❑ No
Blood in Stool	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Constipation	❑ Yes	❑ No

Neurological

Headaches	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No

Hematologic/Lymphatic

Easy Bruising	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No

Endocrine

Thyroid Disease	❑ Yes	❑ No
Heat/Cold Intolerance	❑ Yes	❑ No

Cardiovascular

Chest Pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No

Eyes

Blurred Vision	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Loss of Vision	❑ Yes	❑ No

Skin

Frequent Rashes	❑ Yes	❑ No
Skin Ulcers	❑ Yes	❑ No
Lump	❑ Yes	❑ No
Psoriasis	❑ Yes	❑ No

Head/Ears/Nose/Throat

Hoarseness	❑ Yes	❑ No
Trouble Swallowing	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No

Psychiatric

Depression	❑ Yes	❑ No
Drug/Alcohol Addiction	❑ Yes	❑ No
Suicidal Thoughts	❑ Yes	❑ No

Are there any questions you would like the doctor to address for you at this visit?

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/ Representative Name: _____

Patient Signature: _____ Date: _____

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