ANANT KUMAR, M.D.

New Patient Questionnaire
Thoracic and Lumbar Spine

Please answer all questions completely

_____

Colorado Back and Spine – Dr. Anant Kumar

Date:_____

Patient Name:_____

Referring doctor name and address:_____

If you were not referred by a physician, how did you find our office?_____

Primary care doctor name and address:_____

1. Your age:_____ Years Gender: ☐ Male ☐ Female
2. Symptoms: ☐ BACK pain ☐LEG pain ☐ Numbness ☐ Weakness ☐ Other_____
3. How long have you had your symptoms?_____
4. What caused your symptoms? ☐ Unknown ☐ Injury ☐ Other _____
5. Have your symptoms improved or worsened recently? ☐ Improved ☐ Worsened
6. When did and what caused your symptoms improve or worsen?_____

What % of your symptoms is in the BACK and LEG? (please check one box)	**What % of your symptoms is in each LEG? (please check one box)**
☐ BACK 0%, LEG 100%	☐ No LEG symptoms
☐ BACK 10%, LEG 90%	☐ Right 0%, Left 100%
☐ BACK 25%, LEG 75%	☐ Right 10%, Left 90%
☐ BACK 50%, LEG 50%	☐ Right 25%, Left 75%
☐ BACK 75%, LEG 25%	☐ Right 50%, Left 50%
☐ BACK 90%, LEG 10%	☐ Right 75%, Left 25%
☐ BACK 100%, LEG 0%	☐ Right 90%, Left 10%
	☐ Right 100%, Left 0%

Where in your LEG do you have PAIN or TINGLING?	
Right	**Left**
☐ None	☐ None
☐ Buttock	☐ Buttock
☐ Thigh, back	☐ Thigh, back
☐ Thigh, front	☐ Thigh, front
☐ Calf	☐ Calf
☐ Foot	☐ Foot

Where in your LEG do you have NUMBNESS	
Right	**Left**
☐ None	☐ None
☐ Buttock	☐ Buttock
☐ Thigh	☐ Thigh
☐ Calf	☐ Calf
☐ Ankle	☐ Ankle
☐ Foot/toes	☐ Foot/toes

Where in your LEG do you have WEAKNESS	
Right	**Left**
☐ None	☐ None
☐ Buttock	☐ Buttock
☐ Thigh	☐ Thigh
☐ Calf	☐ Calf
☐ Ankle	☐ Ankle
☐ Foot	☐ Foot

MY BACK PAIN IS (circle number)

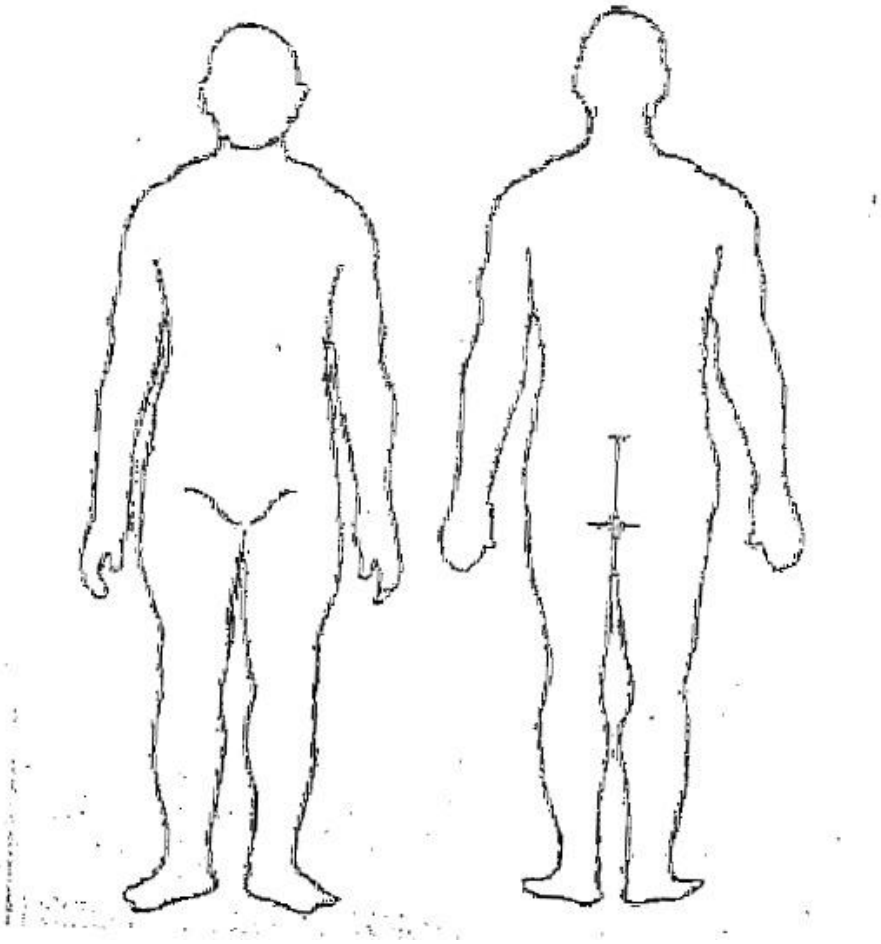
0 1 2 3 4 5 6 7 8 9 10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be

MY LEG PAIN IS (circle number)

0 1 2 3 4 5 6 7 8 9 10

No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be



Please mark the areas on the diagram where you are having symptoms and the location where the symptoms radiate.

Please use the following symbols to indicate the type of symptoms and the location of the symptoms:

Pain= ----------

Pins and Needles= 00000000

Numbness= XXXXXXXXXXX

Colorado Back and Spine – Dr. Anant Kumar

7. **How does your pain travel**:☐ Stays in my BACK ☐ Starts in the BACK and goes down the LEG
8. **The worst position for pain is**: ☐ No pain ☐ Sitting ☐ Standing ☐ Walking
9. **Bending forward?** ☐ Increases the pain ☐ Decreases the pain ☐ No effect
10. **Lying down?** ☐ Increases the pain ☐ Decreases the pain ☐ No effect
11. **How many minutes can you STAND without pain?** ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
12. **How many minutes can you WALK without pain?** ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
13. **Does coughing or sneezing increase your symptoms?** ☐ Yes ☐ No
14. **Do you have difficulty with bowel or bladder control?** ☐ No ☐ Yes; since_____
15. **Have you missed work because of your symptoms?** ☐ No ☐ Yes; how much time _____
16. **Previous treatments for my condition have included**: (check <u>any</u> boxes that apply)
    - ☐ **Nothing** (no medicines, therapy, manipulations, injections, or braces)
    - ☐ <u>Physical therapy</u>: did it help relieve your symptoms?_____
    - ☐ <u>Chiropractic manipulation</u>; did it help relieve your symptoms?_____
    - ☐ <u>Braces</u>; did it help relieve your symptoms?_____
    - ☐ <u>Spine injections</u>: How many injections have you had?_____

      For how long did the injections relieve your pain?_____
    - ☐ <u>Surgery</u>

      How many surgeries have you had on your BACK?_____

      When was/were the surgery(ies) on your BACK?_____

      Did surgery relieve your symptoms?_____
    - ☐ <u>Other treatment</u>:_____
17. **Previous doctors seen for your spine problem:** ☐ None

Doctor	Specialty	City	Recommendations/Treatments

18. **List pain medications and dose taken for your spine problem**: ☐ None

Medication	Dose

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MEDICAL CONDITIONS THAT YOU HAVE OR HAD IN THE PAST: (check all that apply)

☐ None apply

☐ Heart attack	☐ Diabetes	☐ Lung disease	☐ Liver trouble
☐ Heart failure	☐ Stroke	☐ HIV	☐ Hepatitis
☐ High blood pressure	☐ Seizures	☐ AIDS	☐ Thyroid trouble
☐ Osteoarthritis	☐ Mental illness	☐ Tuberculosis	☐ Bleeding disorders
☐ Rheumatoid arthritis	☐ Kidney stones	☐ Asthma	☐ Anemia
☐ Ankylosing spondylitis	☐ Kidney failure	☐ Blood clot in LEG	☐ Blood clot in lung
☐ Gout	☐ Stomach ulcers	☐ Alcoholism	☐ Drug use
☐ Osteoporosis			

☐ Cancer (type)_____

☐ Serious injuries (explain) _____

☐ Other (explain)_____

MEDICATIONS YOU TAKE (please list): ☐ None

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICINE? ☐ No known drug allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to latex? ☐ Yes ☐ No

Have you had complications with anesthesia? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Please list previous surgeries, surgeon and date. ☐ None

OPERATION	SURGEON	DATE

FAMILY HISTORY: (check all that apply)

☐ None apply

☐ Scoliosis ☐ Spine problems ☐ Arthritis ☐ Mental illness ☐ Alcoholism

☐ Heart trouble ☐ Stroke ☐ High blood pressure ☐ Diabetes ☐ Seizures

☐ Cancer ☐ Bleeding disorders ☐ Blood clots ☐ Other _____

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SOCIAL HISTORY: (check all that apply)

1. Work status: ☐ Working: __Full time __ Part time ☐ Retired ☐ Disabled ☐ Unemployed
   Occupation:_____
2. Marital status: ☐ Married ☐ Single ☐ Co-habitating ☐Widowed ☐ Divorced
3. I live: ☐ Alone ☐ With:_____
4. Number of living children:_____
5. Tobacco and nicotine use: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe
   ☐ Cigarettes _____ packs per day for _____ years.
   ☐ Quit – When?_____after smoking_____ packs per day for _____ years
6. Alcohol intake: ☐ Never ☐ <2 drinks/month ☐ 1-2 drinks/week ☐ 1-2 drinks/day
7. Drug use: ☐ Never ☐ Currently ☐ In the past
8. If you have scoliosis how old were you when you started your menstrual cycle?_____
9. Because of my spine problem, I have filed or plan to file:

   ☐ A lawsuit ☐ A Worker's Compensation claim ☐ Neither

REVIEW OF SYSTEMS: (check all that apply)

Constitutional ☐ None apply ☐ Recent weight change ☐ Poor appetite ☐ Hot or cold spells ☐ Fever or chills

Eyes ☐ None apply ☐ Change of vision ☐ Reading glasses

Cardiac ☐ None apply ☐ Abnormal heartbeat ☐ Heart or chest pain ☐ Swollen ankles

Respiratory ☐ None apply ☐ Shortness of breath ☐ Morning cough

Gastrointestinal ☐ None apply ☐ Frequent Constipation ☐ Frequent diarrhea ☐ Stomach pain ☐Ulcers ☐ Nausea or vomiting

Genitourinary ☐ None apply ☐ Frequent urination ☐ Burning with urination ☐ Difficulty starting urination

Neurologic ☐ None apply ☐ Frequent headaches ☐ Blackouts ☐ Seizures ☐ Weakness ☐ Numbness

Skin ☐ None apply ☐ Frequent rash ☐ Acne

ENMT ☐ None apply ☐ Gum trouble ☐ Toothache ☐ Loss of hearing ☐ Cavities ☐ Missing teeth ☐ Dentures ☐ Ear pain/infection ☐ Nosebleeds ☐ Hoarseness ☐ Difficulty swallowing

Heme/Lymph ☐ None apply ☐ Anemia ☐ Blood clots☐ Easily bruising ☐ Bleeding disorder

Psychiatric ☐ None apply ☐ Depression ☐ Schizophrenia ☐ Bipolar disorder ☐ Alcoholism ☐ Drug abuse

Patient Signature _____Date _____

Physician Signature _____Date _____

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Physical Examination (**FOR OFFICE USE ONLY** – Patients continue to the next page)

1. Constitutional:
    a. Vital Signs: Height _____ Weight_____ Pulse_____ Resp_____
    b. Appearance: Nutrition_____ Habitus Deformity Grooming_____
2. Neurological
    a. Orientation (PERSON/PLACE/TIME) Mood/ Affect (depression, anxiety, agitation)
3. SKIN (scars, ulcerations, etc; location); Neck_____ Back BUE BLE_____
4. Adams forward bend: PT_____ MT_____ TL/L_____
5. Pain Range of Motion Cervical/Thoracolumbar Spine (Yes/No)_____
6. Pain palpation Cervical/Thoracolumbar Spine (Yes/No; Location)_____
7. GAIT: Tandem gait: (steady / unsteady); Able to Heel walk: (+ / -); Able to Toe walk:(+ / -)
8. Motor: Delt Bi Tri WE WF FF INT Psoas Quad DF EHL PF INV EVER
    R
    L
9. Sensation: (symmetric, deficits, region of deficit):
10. DTR: Biceps Triceps BR Knee Ankles Babinski Hoffman's Clonus Umbilicus
    R
    L
11. Cardiovascular: DP PT Vascular changes Swelling
    R
    L

Straight LEG raise	
Femoral Stretch Test	
Pain hip ROM	
Pain knee ROM	
Pain Shoulder ROM	
Coordination	
SI pain	
Rhomberg	
Carpal/Cubital tunnel exam	

Lab/EMG Results:

Exam type	Date obtained	Findings

Diagnostic Imaging

Exam type	Date obtained	Findings

Assessment_____

Recommendations: Prescription Drug (mod-mgmt)_____ Physical Therapy (low-mgmt) Injections (high DxP) Surgery (high)

Modified Oswestry Low Back Pain Disability Questionnaire[a]

This questionnaire has been designed to give your doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, **but please mark ONLY the box that most closely describes your current condition.**

[a]Modified by permission of The Chartered Society of Physiotherapy from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy* 1980;66:271-273.

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication
- ☐ The pain is bad, but I can manage without having to take pain medication
- ☐ Pain medication provides me with complete relief from pain
- ☐ Pain medication provides me with moderate relief from pain
- ☐ Pain medication provides me with little relief from pain
- ☐ Pain medication has no effect on my pain

Personal Care (e.g., Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain
- ☐ I can take care of myself normally, but it increases my pain
- ☐ It is painful to take care of myself and I am slow and careful
- ☐ I need help, but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Lifting
- ☐ I can lift heavy weights without increased pain
- ☐ I can lift heavy weights but it gives increased pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Walking
- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile
- ☐ I can only walk with crutches or a cane
- ☐ I am in bed most of the time and have to crawl to the toilet

Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than ½ hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ Pain prevents me from sitting at all

Standing
- ☐ I can stand as long as I want without increased pain
- ☐ I can stand as long as I want, but it increases my pain
- ☐ Pain prevents me from standing more than 1 hour
- ☐ Pain prevents me from standing more than ½ hour
- ☐ Pain prevents me from standing more than 10 minutes
- ☐ Pain prevents me from standing at all

Sleeping
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using pain medication
- ☐ Even when I take pain medication, I sleep less than 6 hours
- ☐ Even when I take pain medication, I sleep less than 4 hours
- ☐ Even when I take pain medication, I sleep less than 2 hours
- ☐ Pain prevents me from sleeping at all

Social Life
- ☐ My social life is normal and does not increase my pain
- ☐ My social life is normal, but it increases my level of pain
- ☐ Pain prevents me from participating in more energetic activities (e.g., sports, dancing)
- ☐ Pain prevents me from going out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of my pain

Traveling

☐ I can travel anywhere without increased pain
☐ I can travel anywhere, but it increases my pain
☐ My pain restricts my travel over 2 hours
☐ My pain restricts my travel over 1 hour
☐ My pain restricts my travel to short necessary journeys under ½ hour
☐ My pain prevents all travel except for visits to the physician/therapist or hospital

Employment/Homemaking

☐ My normal homemaking/job activities do not cause pain
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me
☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
☐ Pain prevents me from doing anything but light duties
☐ Pain prevents me from doing even light duties
☐ Pain prevents me from performing any job or homemaking chores

_____

Patient Signature

_____

Date

Zurich Claudication Questionnaire

Please read: This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box that applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box that most closely describes your problem.

Symptom Severity Scale

1. The pain you have had on average including the pain in your back, buttocks and pain that goes down you legs:

☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild
☐ None

2. How often have you had back, buttock, or leg pain?

☐ Every minute of the day
☐ Everyday for most of the day
☐ Everyday, for at least a few minutes
☐ At least once a week
☐ Less than once a week

3. The pain in your back or buttocks?

☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild
☐ None

4. The pain in your legs or feet?

☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild
☐ None

5. Numbness or tingling in your legs or feet?

☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild
☐ None

6. Weakness in your legs or feet?

☐ Very Severe
☐ Severe
☐ Moderate
☐ Mild
☐ None

7. Problems with your balance?

☐ Yes, often I feel my balance is off, or that I'm not sure footed
☐ Yes, sometimes I feel my balance is off, or that I'm not sure footed
☐ No, I have had no problems with balance

Physical Function Scale

8. How far have you been able to walk?

☐ Less than 50 feet
☐ Over 50 feet, but less than 2 blocks
☐ Over 2 blocks, but less than 2 miles
☐ Over 2 miles

9. Have you taken walks outdoors or in malls?

☐ No
☐ Yes, but always with pain
☐ Yes, but sometimes with pain
☐ Yes, comfortably

10. Have you been shopping for groceries other items?

☐ No
☐ Yes, but always with pain
☐ Yes, but sometimes with pain
☐ Yes, comfortably

11. Have you walked around the different rooms in your house or apartment?

☐ No
☐ Yes, but always with pain
☐ Yes, but sometimes with pain
☐ Yes, comfortably

12. Have you walked from your bedroom to the bathroom?

☐ No
☐ Yes, but always with pain
☐ Yes, but sometimes with pain
☐ Yes, comfortably

_____

Patient Signature

_____

Date