

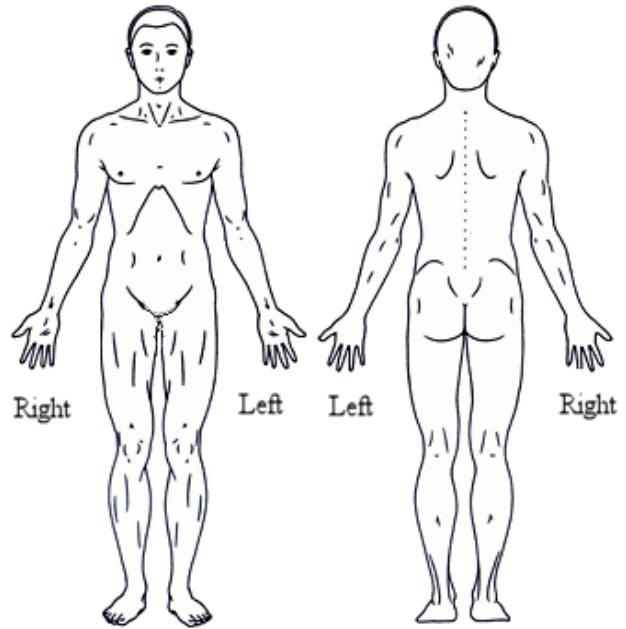
# Mosenthal Spine Clinic

## Patient Symptom Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

- |  |   |   |
|--|---|---|
| Are your symptoms due to an auto accident or work-related accident       | Y | N |
| Did your pain start suddenly without any reason –spontaneous pain?       | Y | N |
| Are your symptom(s) a result of a significant trauma or accident?        | Y | N |
| Do you have a history of cancer?   | Y | N |
| Do you have AIDS/HIV, are on steroids or immunosuppressant drugs?        | Y | N |
| Experience neurological symptoms such as referred pain, limb weakness?   | Y | N |
| Are you noticing weight loss OR have a fever OR concurrent health issue? | Y | N |
| Are you unable to find relief in any posture?                            | Y | N |
| Would you state that you are experiencing rapidly escalating pain?       | Y | N |

Please mark the diagram according to the following:  
 Place a number of your severity (where 1 is very little and 10 is extreme) AND a letter description of the quality in the area(s) of your symptom(s) Example P 5 or R8  
 Pain (P)  
 Ache (A)  
 Radiating (R)  
 Numbness (N)  
 Tingling (T)  
 Throbbing (THR)  
 Other (O) Please describe \_\_\_\_\_



Would you rate you symptom(s) as:  
 \_\_\_ Acute (3 months duration or less)  
 \_\_\_ Chronic (on going for more than 3 months)

Describe how your symptoms came to be  
 (How/When/Where) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Concerning your present symptom(s) have you:  
 Seen your primary physician (PCP)? Y N Name \_\_\_\_\_ If yes, date? \_\_\_\_\_  
 What was your diagnosis? \_\_\_\_\_  
 Did you have an X-ray Y N Finding \_\_\_\_\_  
 Did you have an MRI? Y N Finding \_\_\_\_\_  
 Were you given medication Y N If yes, what? \_\_\_\_\_  
 Did your PCP recommend chiropractic Y N Physical Therapy Y N

What makes your symptom feel better? \_\_\_Nothing \_\_\_Over the counter medicine \_\_\_Ice \_\_\_Heat  
 \_\_\_Being on my back \_\_\_Being on my side \_\_\_Being on my stomach \_\_\_Sitting \_\_\_Walking  
 \_\_\_Other (please describe) \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

Are your current symptoms since the time they first appeared \_\_\_same \_\_\_better \_\_\_worse

Has your current symptoms affected your ability to do your employment? Y N If yes, please describe \_\_\_\_\_

Is there anything else about your current symptom(s) that you feel that we should know about? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Mosenthal Spine Clinic Patient Symptom Questionnaire Page 2

Have you had similar complaints to your current problem? Y N If yes, please tell how many times you have experienced your symptoms, if you have seen any doctors,, any imaging performed and treatment given\_\_\_\_\_

Do You Have or Have Had:

Osteoporosis Y N Former Spinal Surgery Y N Spinal Hardware Y N Spinal Fusion Y N  
Scoliosis Y N AutoImmune Disorder Y N Metal Sensitivities Y N Allergies Y N  
Fibromyalgia Y N Cardio-Vascular Issues Y N Birth Control Y N Pregnant Y N  
Endometriosis Y N GastroIntestinal Problems Y N Respiratory Disorder Y N  
Parkinson's Y N Multiple Sclerosis Y N Are You Taking Light Sensitive Medication Y N  
Other\_\_\_\_\_

If YES above, please describe and tell us if you are on any medications:\_\_\_\_\_

Please tell us of any surgeries/dates that you have had\_\_\_\_\_

Is there any family history of cancer, low back issues, arthritis, or any other health issues that may be a factor in your current symptoms? Y N If yes, please describe\_\_\_\_\_

Height\_\_\_\_\_Weight\_\_\_\_\_Handedness R L Your Blood Pressure is\_\_\_Normal \_\_\_High

Do you smoke Y N If yes, how many cigarettes per day \_\_\_\_\_

How many alcoholic oz per day\_\_\_\_\_ Number of glasses of water that you drink per day\_\_\_\_\_

Number of caffeinated cups per day?\_\_\_\_\_

Does your work involve prolonged standing, bending or sitting, lifting heavy objects or working with vibrating tools? Y N

How would you rate your current level of physical fitness \_\_\_Above Average \_\_\_Average

\_\_\_Below Average What is your primary exercise?\_\_\_\_\_

How would you rate your daily posture? \_\_\_Above Average \_\_\_Average \_\_\_Below Average

Do you feel that anxiety, depression, stress, negative job satisfaction, family and/or social factors are a cause of your current symptoms Y N

Do you have any sleep issues? \_\_\_No, I wake up very well rested w/no spinal stiffness or soreness

\_\_\_No, but my current symptoms are negatively affecting my sleep

\_\_\_No, but I usually wake up with some spinal stiffness

\_\_\_Yes, I do have sleeping issues

Any foot issues? Y N Please describe\_\_\_\_\_

Would you say you wear "supportive shoes" (high heels/flats are NOT supportive) \_\_\_Yes \_\_\_No

Any knee, hip, shoulder issues Y N Please describe \_\_\_\_\_

Do you feel that any of the following are contributing to your current symptom(s)

\_\_\_Non-supportive mattress \_\_\_Non-supportive night pillow \_\_\_Poor ergonomics at work or home

\_\_\_Poor car seat \_\_\_Lack of exercise/stretching \_\_\_Use of phone/lack of headset \_\_\_Weight

Do you see a massage therapist on a regular basis? Y N If yes, who\_\_\_\_\_

Do you see a naturopath or acupuncturist? Y N Names\_\_\_\_\_

Favorite hobbies/interests/passions\_\_\_\_\_

Daily vitamins supplements that you take\_\_\_\_\_

Please list any other information that you think would help us to help you better\_\_\_\_\_

Signature of Patient\_\_\_\_\_Date\_\_\_\_\_