

Orthopaedics and Rehabilitation Excellence of Miami
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Orthopaedic Surgeon, Board Certified

Spine Symptom and Pain Questionnaire

Last Name _____ First Name _____ MI _____

Age _____ Occupation _____

What hurts?: () Cervical/Neck () Thoracic/Upper back () Lumbar/Low Back () Right () Left () Both

When did your pain/complaint begin?: _____

Describe how you injured yourself: _____

Rate your pain/discomfort (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

My pain is best described as (check all that apply): () Constant () Frequent () Occasional () Sharp () Throbbing () Burning () Electrical Shock () Tightness () Dull () Cramping () Achy () Nothing () Radiates into my shoulders () Radiates down my arm () Radiates down my legs

Are you experiencing numbness?: () No () Yes If yes, location _____

My pain is (check all that apply):	Better	Worse	No Change
In the morning	_____	_____	_____
Bending forward	_____	_____	_____
Sitting in the car	_____	_____	_____
During the mid-day	_____	_____	_____
Lying on my stomach	_____	_____	_____
Coughing or sneezing	_____	_____	_____
Prolonged walking/standing	_____	_____	_____
Prolonged sitting	_____	_____	_____

Pain relieved by: () Rest () Activity () Heat () Ice () Medication, if so list _____

Is your injury interfering with sports and/or activities of daily living: () No () Yes

Treatment to date (check all that apply):

- () None
- () Emergency Room _____ which ER _____
- () Medication, list _____ with what results: () Better () Worse () Same
- () Epidural injection, when _____ By who? _____ with what results: () Better () Worse () Same
- () MRI/x-ray, when _____ who ordered it _____
- () Physical therapy, if so how long _____ with what results: () Better () Worse () Same
- () Surgery, procedure _____ Surgeon _____ date _____
- () Other, describe _____

Patient Signature: _____ Date ____/____/____

Reviewed By: _____ MD/PA/MA Date ____/____/____