EAST BAY BRAIN & SPINE
MEDICAL GROUP

SPINE QUESTIONNAIRE

Patient Name:	Patient DOB:

PRESENT CONDITION

Please tell us a bit about your present illness:

1. What is the reason for your visit today? _____
2. How long have you had the problem? _____
3. How severe is the problem? _____
4. What type of symptoms are you experiencing? _____
5. How often do your symptoms occur? _____
6. How long do your symptoms last? _____
7. Is there anything that makes the problem worse? _____
8. Does anything make the problem better? _____
9. Have you ever had treatment for this problem? _____
10. Please rate your current level of pain on a scale from 0 (least) to 10 (greatest)? _____

PREVIOUS TREATMENT

Please check all prior treatments you have tried.

☐ surgery
☐ brace
☐ wrist splints
☐ physical therapy
☐ chiropractor
☐ exercise program
☐ yoga or pilates

☐ anti-inflamatory medications (Motrin, Naproxen, Ibuprofen)
☐ narcotic pain medication (Percocet, Norco, Oxycodone)
☐ muscle relaxants (Cyclobenzaprine)

☐ epidural steroid injection(s)
____ times _____ most recent date

These provided:
☐ no relief
☐ relief for 1-4 weeks
☐ relief for 5-8 weeks
☐ relief for 8+ weeks

PAIN MANAGEMENT

Are you currently in Pain Management or receiving pain medication from another physician? Yes No
If yes, please list below the name, address, and phone/fax number for the prescribing physician.

Physician Name: _____ Physician Phone Number: _____

Physician Address: _____ Physician Fax Number: _____