SPINE PATIENT QUESTIONNAIRE

Please answer the following questions with the most accurate response possible. If some of the questions are unclear or do not apply, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your visit, and you can clarify your answers at that time. Thank you.

(check all that apply)

B. For patients with NECK OR ARM PAIN

D. ALL PATIENTS should answer the following:

Doctor	*Specialty*	*City*	*Treatments*

City	*Date*

E. MEDICATIONS YOU TAKE FOR <u>ALL</u> HEALTH ISSUES: (list dose and frequency):

Medication	*Dosage*

F. MEDICATIONS YOU HAVE TRIED FOR YOUR SPINE PROBLEM (list dose and frequency):

Medication	*Dosage*

G. ***MEDICATIO***

L. FAMILY HISTORY (list any illnesses that "run" in your family):

M. REVIEW OF SYSTEMS (check all that apply):