

Name:
DOB:
Age:
Chart:

Date:

Orthopaedic Surgery Associates

O F M A R Q U E T T E P C

www.upbonedoctors.com

Office: 906-225-1321 Business Fax: 906-228-9371 Clinic Fax: 906-225-3968

Scoliosis Patient Questionnaire:

Patient Name: _____ Age: _____ Date: _____

Medical Record # _____ SS: _____

Exam: Pre-treatment 3 months 6 months 1 year ___ years

Your doctors are carefully evaluating the condition of your back before and after your treatment. Please circle the one best answer to each question unless otherwise indicated. If you already have had surgery, please complete sections 1 and 2. Otherwise, just complete section 1.

All results will be kept confidential.

Section 1: All patients

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?
 None Moderate to severe
 Mild Severe
 Moderate
2. Which one of the following best describes the amount of pain you have experienced over the last month?
 None Moderate to severe
 Mild Severe
 Moderate
3. During the past 6 months have you been a very nervous person?
 None of the time Most of the time
 A little of the time All of the time
 Some of the time
4. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?
 Very happy Somewhat unhappy
 Somewhat happy Very unhappy
 Neither happy or unhappy
5. What is your current level of activity?
 Bedridden/wheelchair
 Primarily no activity
 Light labor, such as household chores
 Moderate manual labor and moderate sports, such as walking and biking
 Full activities without restriction
6. How do you look in clothes?
 Very good
 Good
 Fair
 Bad
 Very bad
7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?
 Very often Rarely
 Often Never
 Sometimes
8. Do you experience back pain when at rest?
 Very often Rarely
 Often Never
 Sometimes
9. What is your current level of work/school activity?
 100% normal 25% normal
 75% normal 0% normal
 50% normal
10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?
 Very good Poor
 Good Very poor
 Fair
11. Which one of the following best describes your medication usage for your back?
 None
 Non-narcotics weekly or less (e.g., Tylenol, Ibuprofen)
 Non-narcotics daily
 Narcotics weekly or less (e.g. Percocet, Lorcet, Codeine, Darvocet)
 Narcotics daily
 Other (please specify below)
Medication: _____
Usage (weekly or less or daily): _____

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12. Does your back limit your ability to do things around the house?

- Never Often
 Rarely Very often
 Sometimes

13. Have you felt calm and peaceful during the past 6 months?

- All of the time A little of the time
 Most of the time None of the time
 Some of the time

14. Do you feel that your back condition affects your personal relationships?

- Severely Slightly
 Moderately None
 Mildly

15. Are you and/or your family experiencing financial difficulties because of your back?

- Severely Slightly
 Moderately None
 Mildly

16. In the past 6 months have you felt down hearted and blue?

- Never Often
 Rarely Very often
 Sometimes

17. In the last 3 months have you taken any sick days from work/school due to back pain and, if so, how many?

- 0 1 2 3 4 or more

18. Do you go out more or less than your friends?

- Much more Less
 More Much less
 Same

19. Do you feel attractive with your current back condition?

- Yes, very No, not very much
 Yes, somewhat No, not at all
 Neither attractive nor unattractive

20. Have you been a happy person during the past 6 months?

- None of the time Most of the time
 A little of the time All of the time
 Some of the time

21. On a scale of 1 to 9, with 1 being very low and 9 being extremely high, how would you rate your self-image?

- 1 2 3 4 5 6 7 8 9

22. Are you satisfied with the results of your back management?

- Very satisfied Unsatisfied
 Satisfied Very unsatisfied
 Neither satisfied nor unsatisfied

23. Would you have the same management again if you had the same condition?

- Definitely yes Probably not
 Probably yes Definitely not
 Not sure

Section 2: Post-surgery patients only

24. Compared with before treatment, how do you feel you now look?

- Much better Worse
 Better Much worse
 Same

25. Has your back treatment changed your function and daily activity?

- Increased Not changed Decreased

26. Has your back treatment changed your ability to enjoy sports/hobbies?

- Increased Not changed Decreased

27. Has your back treatment _____ your back pain?

- Increased Not changed Decreased

28. Has your treatment changed your confidence in personal relationships with others?

- Increased Not changed Decreased

29. Has your treatment changed the way others view you?

- Much better Worse
 Better Much worse
 Same

30. Has your treatment changed your self image?

- Increased Not changed Decreased

Patient Name: _____
Print Name

Patient Signature: _____

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PEDIATRIC SPINE PATIENT QUESTIONNAIRE

Answer accurately to help us evaluate and treat your child's problem. Ask the nurse if you have questions.

DATE _____ NAME _____ AGE _____ SEX: _____

Who referred you to this clinic? (name and address) _____

Name of your primary care physician (name and address) _____

ONSET

When was the problem noted (month and year)? _____

How was the problem noted? School screening Parents/Family/Friends Pediatrician/doctor

What was noted? Shoulder asymmetry Rib or back prominence Round back Sway back Other _____

Has the deformity been getting worse? Yes No Do you wear clothing to hide your shape? Yes No

QUALITY AND LOCATION OF ANY PAIN

Nature: Sharp Dull Ache Burning Numbness Pins & Needles

Area: Upper back pain Low back pain Neck pain Leg pain: right left Arm pain: right left

Severity of pain: (On a scale of 1 to 10, 10 being worst possible)

Rated at its worse, what # _____ At its best what # _____

What affects the pain?

Worse with: Standing Walking Sitting Lying Coughing Bathroom No difference

Better with: Standing Walking Sitting Lying

Time-Dependent Pattern

Progress: Improving Same Getting Worse Worse in: Morning Afternoon Night

Other characteristics about your pain:

MOTOR FUNCTION

Weakness in: Arms Legs Both Where? _____

Trouble with balance, equilibrium or walking? Yes No Problems with: Bowel or Bladder: Yes No

PAST MEDICAL HISTORY

Past medical problems: _____

Past surgeries:

Developmental history:

At how many months of age did the patient: Sit by self? _____ Stand alone? _____ Walk alone? _____

Ride a bicycle? _____ If a female patient; age and date of first menstrual period (month and year): _____

Can the child keep up physically with their friends of similar age? Yes No If no, Describe: _____

ALLERGIES: Yes No If no, Describe: _____

MEDICATIONS:

List all current medications: _____

FAMILY HISTORY

Siblings: # of brothers: _____ # of sisters: _____ Parents: both at home: single parent: mom dad Other: _____

Are there spine problems in the family? Yes No Other medical problems in family members? Yes No

Please list who and what is wrong: _____

SOCIAL HISTORY

Grade level: _____ Job/work: _____

Smoking: Yes No Oral tobacco (chew/snuff) Yes No Alcohol / Drug use: Yes No

CONSTITUTIONAL SIGNS / REVIEW OF SYSTEMS: (check areas giving trouble and explain to doctor)

| | | |
|--|--|---|
| fever <input type="checkbox"/> | eye problems <input type="checkbox"/> | cough <input type="checkbox"/> |
| night sweats <input type="checkbox"/> | ear problems <input type="checkbox"/> | breathing difficulty <input type="checkbox"/> |
| cold sweats <input type="checkbox"/> | nose problems <input type="checkbox"/> | bleeding problems <input type="checkbox"/> |
| weight loss <input type="checkbox"/> | throat problems <input type="checkbox"/> | stomach pain <input type="checkbox"/> |
| weight gain <input type="checkbox"/> | chest pain <input type="checkbox"/> | urinary dysfunction <input type="checkbox"/> |
| vision problems <input type="checkbox"/> | palpitations <input type="checkbox"/> | bowel dysfunction <input type="checkbox"/> |

"Is there anything else bothering you?" _____

Patient/Guardian: _____ Parent/Guardian Signature: _____

Print Name