Weill Cornell Medicine

Och Spine at NewYork-Presbyterian/
Weill Cornell Medical Center
Phone: (888) 922-2257 (888-WC-BACKS)
Please return this form to our office via fax: (646)-962-0640

Please note which department or physician you are requesting to see: _____

Neurosurgery Neurology Pain Management Physiatry/Rehab Medicine

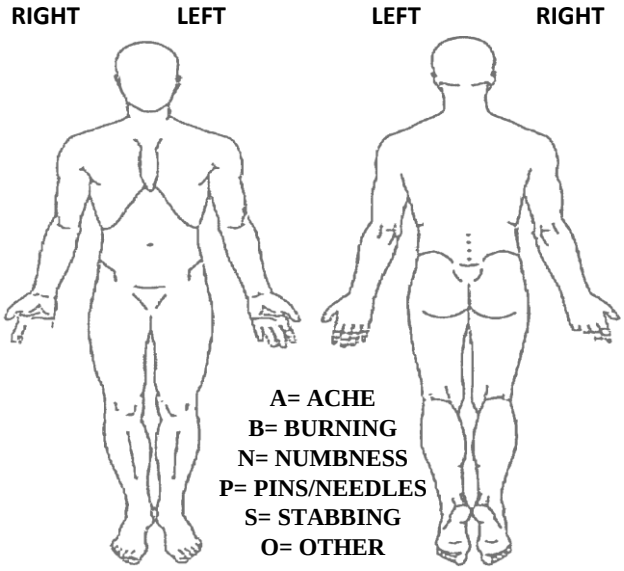
NEW PATIENT QUESTIONNAIRE

DATE: _____

Patient Name:_____ **Date of Birth**:_____/_____/_____ **Gender**: M or F
Phone Number: _____ **Address**:_____
Referred by _____ **Insurance Carrier/ ID or Policy #** _____
Reason for Visit: _____
Have you had a history of accident or injury? If **yes**, please explain and answer the next three questions:
_____

- Was the accident at work? Yes or No
- Are you using Workers' Compensation? Yes or No
- Are you currently involved in litigation? Yes or No

On the diagram below, please mark where you are feeling your symptoms with the appropriate letters.



Please note if other: _____

1. When did the pain begin? _____

Duration of Pain: _____

Overall the pain is:

Improved Worse Stable

2. Quality of Pain (check all that applies)?

☐ Sore	☐ Aching ☐ Burning	
☐ Sharp	☐ Dull	☐ Tender
☐ Stabbing	☐ Tingling	☐ Cramping
☐ Shooting	☐ Pulling	☐ Radiating
☐ Unsure	☐ Throbbing	

On a scale of 0 to 10, please circle your level of pain or discomfort
0 being none and 10 being unbearable for the following areas:

1. Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
2. Left Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
3. Right Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
4. Left Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
5. Right Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
6. Back Pain:	0	1	2	3	4	5	6	7	8	9	10
7. Left Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
8. Right Hip/Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
9. Left Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
10. Right Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
11. Left Foot Pain:	0	1	2	3	4	5	6	7	8	9	10
12. Right Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

If you are <u>not experiencing pain</u> as a symptom, please skip Questions 1-7.

3. What makes the pain better (check all that applies)?

☐ Heat	☐ Cold	☐ Bend Forward
☐ Bend Back	☐ Change Position ☐ Sitting	
☐ Standing	☐ Walking	☐ Twisting
☐ Movement	☐ Change in weather	☐ Lying Supine
☐ Rest	☐ Valsalva	☐ Coughing/Sneezing
☐ Nothing	☐ Sex	☐ N/A

4. What makes the pain worse (check all that applies)?

☐ Heat	☐ Cold	☐ Bend Forward
☐ Bend Back	☐ Change Position ☐ Sitting	
☐ Standing	☐ Walking	☐ Twisting
☐ Movement	☐ Change in weather	☐ Lying Supine
☐ Rest	☐ Valsalva	☐ Coughing/Sneezing
☐ Nothing	☐ Sex	☐ N/A

5. Pain interferes with:

☐ Sleep ☐ Appetite ☐ Sex
☐ Self-Care ☐ Hobbies ☐ Job Performance
☐ Driving ☐ Social Life ☐ Exercise
☐ Lifting ☐ Traveling ☐ Shopping
☐ Household Chores ☐ Cooking
☐ Other _____

6. When is the pain worst? (Circle one)

Morning Afternoon Evening Night

7. If pain limits activity, please full in all that apply:

I can't tolerate walking more than _____ blocks.
I can't tolerate sitting more than _____ minutes.
I can't tolerate standing more than _____ minutes.
I can't tolerate lying more than _____ minutes.

8. Do you experience weakness? Yes or No

If yes, please describe (include location)_____

Have you had any of the following imaging studies? If yes, please include the date.

IF SO, PLEASE FORWARD A COPY OF THE REPORT TO THE OFFICE PRIOR TO YOUR APPOINTMENT!

X-ray _____ Bone Scan_____ MRI_____

CT scan _____ EMG _____

Below, indicate past treatments for your neck/back condition and include the date of treatment:

Nerve Block_____ Steroid Injections_____

Physical Therapy_____ Psychotherapy_____

Acupuncture_____ Surgery_____

Chiropractic_____ Failed Medications_____

Other_____

If surgery is recommended, what would be your timeframe available for scheduling? _____

REVIEW OF SYSTEMS:

GENERAL
Fatigue □ NO □ YES
Weight loss □ NO □ YES
Weakness □ NO □ YES
Swollen Lymph nodes □ NO □ YES

HEAD
Visual problems □ NO □ YES
Ear pain, decreased hearing □ NO □ YES
Difficulty swallowing □ NO □ YES
Other_____

CHEST, HEART, AND LUNGS
Shortness of breath □ NO □ YES
Chest pain or pressure attacks □ NO □ YES
Frequent cough □ NO □ YES
Swollen ankles □ NO □ YES
Valve disorder □ NO □ YES
Sleep Apnea □ NO □ YES
DVT □ NO □ YES
Stents □ NO □ YES
Other_____

ENDROCRINE
Thyroid condition ☐ NO ☐ YES
Diabetes ☐ NO ☐ YES
Other_____

KIDNEY
Difficulty in passing urine □ NO □ YES
Getting up at night to urinate □ NO □ YES

GASTROINTESTINAL
Poor appetite ☐ NO ☐ YES
Indigestion or vomiting ☐ NO ☐ YES
Change in bowel habits ☐ NO ☐ YES
Pass blood from rectum ☐ NO ☐ YES

MUSCULOSKELETAL
Decreased Range of Motion □ NO □ YES
Joint Swelling □ NO □ YES
Joint Stiffness □ NO □ YES
Muscle Aches/Pains □ NO □ YES

NEUROLOGICAL
Dizziness/Vertigo □ NO □ YES
Headaches □ NO □ YES
Strokes □ NO □ YES
Seizures □ NO □ YES
Tremor □ NO □ YES
Numbness □ NO □ YES

PSYCHOLOGICAL
Anxiety □ NO □ YES
Depression □ NO □ YES
Other_____

History of Cancer? Yes No
If yes, type: _____
Chemo: Yes No
Radiation: Yes No

Please notify the MD/NP/PA/RN if you are pregnant: Yes No

Current Medication:	Dosage:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any allergies to: Shellfish Iodine Latex Contrast/IV dye

Allergies	Reaction
1.	
2.	
3.	

Social History:

1. **Are you a:** Current Smoker / Never Smoker / Former Smoker **Quit Date:** _____
   Type: _____ **Packs/day**:_____ **Years:** _____
2. **Do you use chewing and/or smokeless tobacco?** Yes or No **Have you quit?** Yes or No
   When? _____
3. **Do you drink alcohol?** Yes or No **Type(s):** _____ **Amount**: _____ **How often**:_____
4. **Do you use illicit (street) drug**s? Yes or No **Type(s):** _____ **Last used**:_____
5. **Marital Status**: Single Married Cohabitating Separated Divorced Widowed
6. **Who do you live with**? Alone Spouse Children Parents Other:_____
7. **What is your occupation**? _____
8. **Are you disabled**? Yes or No **If yes, note disability**: _____

Medical/Personal History:

Are you right- or left-handed? Right Left Ambidextrous

Past Medical History:

_____

_____

Past Surgical History and Dates:

_____

_____

Family Medical History:

_____

Please share any other information you would like us to know:

_____

_____

Preferred Pharmacy:

Name:_____ Phone Number:_____

Address:_____

If this form was completed by someone other than the patient, please list the name, relation to the patient and the reason that the patient was unable to complete the form.

Form Completed by_____ Date_____

Weill Cornell Medicine

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but can manage most of my personal care
- o I need help every day in most aspects of self-care
- o I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives me extra pain
- o Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- o Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- o I can only lift very light weights
- o I cannot lift or carry anything

Section 4: Walking*

- o Pain does not prevent me walking any distance
- o Pain prevents me from walking more than 1 mile
- o Pain prevents me from walking more than ½ mile
- o Pain prevents me from walking more than 100 yards
- o I can only walk using a cane or crutches
- o I am in bed most of the time

Section 5: Sitting

- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me sitting more than one hour
- o Pain prevents me from sitting more than 30 minutes
- o Pain prevents me from sitting more than 10 minutes
- o Pain prevents me from sitting at all

Section 6: Standing

- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing for more than 1 hour
- o Pain prevents me from standing for more than 30 minutes
- o Pain prevents me from standing for more than 10 minutes
- o Pain prevents me from standing at all

Section 7: Sleeping

- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain I have less than 6 hours sleep
- o Because of pain I have less than 4 hours sleep
- o Because of pain I have less than 2 hours sleep
- o Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9: Social Life

- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- o Pain has restricted my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10: Travelling

- o I can travel anywhere without pain
- o I can travel anywhere but it gives me extra pain
- o Pain is bad but I manage journeys over two hours
- o Pain restricts me to journeys of less than one hour
- o Pain restricts me to short necessary journeys under 30 minutes
- o Pain prevents me from travelling except to receive treatment

Weill Cornell Medicine

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each sectiononly the one box that applies to you. We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but can manage most of my personal care
- o I need help every day in most aspects of self care
- o I do not get dressed, I wash with difficulty and stay in bed

Section 3: Llfting

- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives extra pain
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- o I can only lift very light weights
- o I cannot lift or carry anything

Section 4: Reading

- o I can read as much as I want to with no pain in my neck
- o I can read as much as I want to with slight pain in my neck
- o I can read as much as I want with moderate pain in my neck
- o I can't read as much as I want because of moderate pain in my neck
- o I can hardly read at all because of severe pain in my neck
- o I cannot read at all

Section 5: Headaches

- o I have no headaches at all
- o I have slight headaches, which come infrequently
- o I have moderate headaches, which come infrequently
- o I have moderate headaches, which come frequently
- o I have severe headaches, which come frequently
- o I have headaches almost all the time

Section 6: Concentration

- o I can concentrate fully when I want to with no difficulty
- o I can concentrate fully when I want to with slight difficulty
- o I have a fair degree of difficulty in concentrating when I want
- o I have a lot of difficulty in concentrating when I want
- o I have a great deal of difficulty in concentrating when I want
- o I cannot concentrate at all

Section 7: Work

- o I can do as much work as I want to
- o I can only do my usual work, but no more
- o I can do most of my usual work, but no more
- o I cannot do my usual work
- o I can hardly do any work at all
- o I can't do any work at all

Section 8: Drlving

- o I can drive my car without any neck pain
- o I can drive my car as long as I want with slight pain in my neck
- o I can drive my car as long as I want with moderate pain in my neck
- o I can't drive my car as long as I want because of moderate pain in my neck
- o I can hardly drive at all because of severe pain in my neck
- o I cannot drive my car at all

Section 9: Sleeplng

- o I have no trouble sleeping
- o My sleep is slightly disturbed (less than 1 hr sleepless)
- o My sleep is mildly disturbed (1-2 hrs sleepless)
- o My sleep is moderately disturbed (2-3 hrs sleepless)
- o My sleep is greatly disturbed (3-5 hrs sleepless)
- o My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- o I am able to engage in all my recreation activities with no neck pain at all
- o I am able to engage in all my recreation activities, with some pain in my neck
- o I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- o I am able to engage in a few of my usual recreation activities because of pain in my neck
- o I can hardly do any recreation activities because of pain in my neck
- o I can't do any recreation activities at all