Patient Name: _____ Date: _____

Spine Intake Questionnaire

Please answer the following questions. These questions will help your therapist to develop an individualized treatment plan for you.

1A. Have you been recently ill or are you currently ill (e.g. recent infection)? YES / NO
1B. Do you have a fever (> 100 degrees)? YES / NO
1C. Is your immune system compromised? YES / NO
1D. Have you recently received intravenous drugs? YES / NO
1E. Does movement worsen your pain and rest improve your pain? YES / NO

2A. Are you greater than 50 years old? YES / NO
2B. Have you ever had cancer? YES / NO
2C. Do you experience night pain that awakens you or does not allow you to fall back asleep? YES / NO
2D. Have you experienced any unintentional weight loss (i.e. > 10 pounds)? YES / NO

3A. Have you been told you have osteopenia (low bone density) or osteoporosis? YES / NO
3B. Have you ever had a spinal fracture? YES / NO
3C. Have you had a decrease in height of > 2 inches over your lifetime or a height loss of > 1 inch over the last 1-3 years? YES / NO

4A. Do you have any symptoms (i.e. pain, numbness, or tingling) in your arm(s) or hand(s)? YES / NO
4B. Have you had any changes in your handwriting? YES / NO
4C. Have you found that you are frequently dropping things? YES / NO
4D. Have you noticed a decrease in your grip strength? YES / NO
4E. Have you noticed that your balance is off? YES / NO

5A. Are you experiencing any bowel or bladder problems? YES / NO
5B. Are you experiencing any sexual functioning problems? YES / NO
5C. Are you experiencing any numbness or tingling in your groin region? YES / NO
5D. Are you experiencing leg weakness? YES / NO

6A. Are you less than 40 years old? YES / NO
6B. Do you have morning stiffness in your spine? YES / NO
6C. Does your pain awaken you during the second half of the night? YES / NO
6D. Do your symptoms improve with movement or activity? YES / NO
6E. Do you ever experience muscle spasms in your back or neck? YES / NO
6F. Do you ever experience alternating pain in your buttock? YES / NO

7A. Are you greater than 50 years old? YES / NO
7B. Do you have morning stiffness in your hip that lasts less than 60 minutes? YES / NO
7C. Do you have hip pain with squatting? YES / NO

8A. Are you experiencing any headaches? YES / NO
[If you answered NO to 8A, you are finished with this sheet.]

If you answered YES to 8A, please answer the following:
8B. Rate the intensity of your headaches from 0=no pain to 10=worst possible pain: _____/10
8C. Which of the following best describes the location of your headaches? Right / Left / Right & Left
8D. Would you describe your headaches as intermittent or constant? Intermittent / Constant
8E. How long do your headaches last? _____
8F. Are there any foods/drinks or environmental factors that trigger your headaches?
If Yes, list: _____
8G. Are you taking any medications for your headaches?
If Yes, list: _____