



PATIENT QUESTIONNAIRE

Charles V. Burton, M.D., F.A.C.S.

Date _____

Name _____ SS# _____
First Middle Last

Date of Birth _____ Present Age _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Your E-Mail _____ (if none give relative's E-Mail) _____

Fax Number (To Which Your Confidential Medical Information Can Be Sent) _____

Present Occupation _____ Previous Occupation _____

Place of Present Employment _____ Phone# _____

Name of Spouse _____ Marital Status ___ Married ___ Divorced ___ Widowed
(or) Name of Significant Other _____

Name, Address, and Specialty of Your Referring Health Professional _____

Referring Health Professional Phone# _____ Fax Number# _____

Name and Address of Your Primary Care Physician _____

Primary Care Physician Phone# _____ Fax# _____

Name of Contact Person Not Living With You _____ Phone# _____

Local Pharmacy Phone# _____ Fax# _____

Do You Work Full-Time? _____ Yes ___ No

Does Your Problem Involve a Lawsuit, Motor Vehicle Accident, or Worker's Compensation Claim?

If the answer to the above is Yes please also go to, and fill out, the last page.

Have Any of Your Family Members Had Back Problems? _____ Yes ___ No

Have Any of Your Family Members Had Back Surgery? _____ Yes ___ No

What Is Your Spine Problem at This Time? _____

How Long Has This Problem Been Present? _____

How Did the Problem Start? ___ Suddenly? ___ Gradually? Post-Injury? ___ Yes ___ No

If Injury, Was This a Work-Related Injury? ___ Yes ___ No If Yes, State Date and Circumstances: _____

Have You Had Other Significant Spine Injuries in the Past? ___ Yes ___ No

What Makes Your Pain Worse? ___ Lifting ___ Bending ___ Twisting

(Check All That Apply) ___ Sitting ___ Standing ___ Walking

___ Running ___ Lying Down ___ Position Change

___ Sleeping ___ Coughing ___ Sneezing ___ Straining

What Makes Your Pain Better? Lying Down Sitting Standing

(Check All That Apply)

Pain Meds Anti-Inflammatories Walking

At This Time Please Fill Out the Pain Drawing Below:

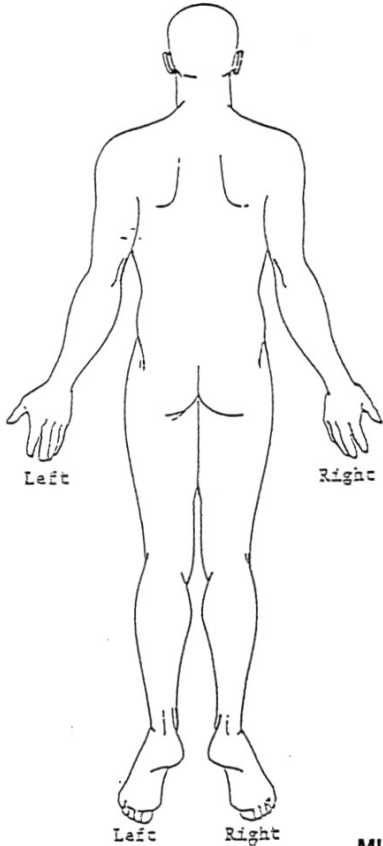
Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHING: = = = =

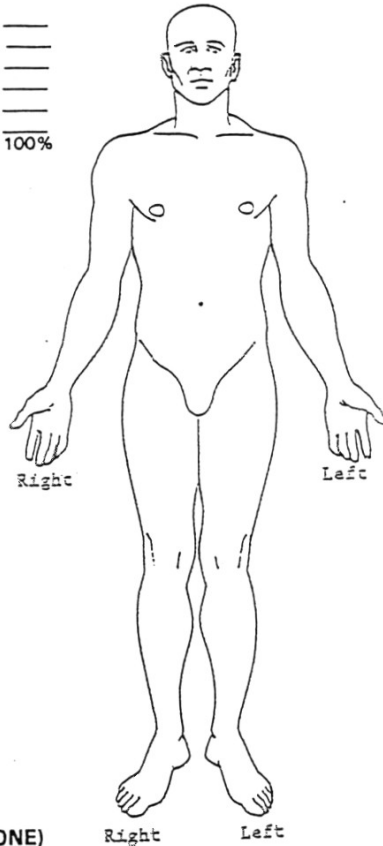
PINS & NEEDLES: 0000

BURNING: XXXX

SHARP & STABBING: ///



- 1. % PAIN IN LOW BACK _____
- 2. % PAIN IN RT. BUTTOCK _____
- 3. % PAIN IN LT. BUTTOCK _____
- 4. % PAIN IN RIGHT LEG _____
- 5. % PAIN IN LEFT LEG _____
- 6. % PAIN ELSEWHERE _____
- TO TOTAL: 100%



PAIN SCALE (CIRCLE ONE)
MINIMAL 1 2 3 4 5 6 7 8 9 10 MAX

Choose no more than five that describe your pain. Please (X). Most important (XX).

- | | | | |
|--------------------|---------------------|-------------------|--------------------|
| 1. Steady [] | 5. Intermittent [] | 9. Electrical [] | 13. Throbbing [] |
| 2. Tiring [] | 6. Punishing [] | 10. Killing [] | 14. Miserable [] |
| 3. Crawling [] | 7. Boring [] | 11. Gnawing [] | 15. Heavy [] |
| 4. Suffocating [] | 8. Cruel [] | 12. Annoying [] | 16. Unbearable [] |

If There is Weakness of an Arm or Leg, Completely Blacken That Area

Which of These Diagnostic Studies Have You Had?

MRI CT Scan Plain X-Rays Myelogram EMG

Which of the Following Have You Had for this Current Problem? (Check All That Apply)

Oil Myelogram Chiropractic Care Physical Therapy

Epidural Steroid Injection Trochanteric Injection Facet Injections

List Current Pain, Anti-Inflammatory, and Anti-Spasm Medications Below:

List All Other Present Medications Below (Please Attach List if Space is Inadequate):

Are You on Any Anti-Coagulant Drugs at This Time? ___ Yes ___ No

Are You on Any Steroids at This Time? ___ Yes ___ No

Are You Allergic to Any Medications? ___ Yes ___ No

If Yes, List These Medications and Your Reaction to Them: _____

PRESENT SYSTEM REVIEW: (Check All Items Which Apply to You)

- | | | |
|-------------------------|-----------------------------------|---|
| ___ Excessive Stress | ___ Heart Problems | ___ Cancer |
| ___ Bladder Problems | ___ Irregular Heart Rate | ___ Painful Joints |
| ___ Bowel Problems | ___ Frequent Chest Pain | ___ Seizures or Blackouts |
| ___ Stomach Problems | ___ Frequent Shortness of Breath | ___ Severe Headaches |
| ___ Frequent Infections | ___ Bleeding or Bruising Tendency | ___ Significant Weight Gain
or Weight Loss |

PAST MEDICAL HISTORY REVIEW (Check Items Which Have Been Issues for You)

- | | | |
|----------------|-------------------------|-------------------|
| ___ Arthritis | ___ Heart Disease | ___ Neck Problems |
| ___ Cancer | ___ Hepatitis | ___ Osteoporosis |
| ___ Depression | ___ High Blood Pressure | ___ Seizures |
| ___ Diabetes | ___ High Cholesterol | ___ Suicide |

PATIENT SPINE RELATED SURGICAL HISTORY (List Below)

Procedure	Date	Hospital Location	Surgeon
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PATIENT NON-SPINE RELATED SURGICAL HISTORY (Please List)

FAMILY HISTORY

(Check off those involving immediate family and add identification as to:

Mother= (M) Father= (F) Sister= (S) Brother= (B) Grandparents= (G)

_____Back Problems _____Genetic (Genomic) Back Problems _____Scoliosis
Identify Family Members Who Have Had Back Surgery_____

_____Abnormal Bleeding _____Heart Disease _____Lupus
_____Anesthesia Problems _____Hepatitis _____Neck Problems
_____Cancer (Type) _____High Blood Pressure _____Osteoporosis
_____Depression _____High Cholesterol _____Rheumatoid Arthritis
_____Diabetes _____Lung Problems _____Seizures

SOCIAL HISTORY

Married? ___Yes ___No Children ___Yes ___No If Yes Ages_____

Cigarette Smoker? ___Yes ___No If Yes Give Amount per Day_____# Years_____

List Any Other Nicotine Products That You Use_____

Are You Aware That Smokers Have a 3-4x Higher Incidence of Disc Degeneration Than Non-Smokers? ___Yes ___No

Alcohol Consumption? ___Yes ___No Amount? Week_____

Do You Exercise Now? ___Yes ___No Daily? ___Yes ___No

Type of Exercise_____

If No, What Exercise Have You Done in the Past?

Have You Had A Chemical Dependency or Drug Addiction Problem? ___Yes ___No

If Yes, State the Number of Years You Have Been Drug Free_____

Who Prescribes Your Narcotic Medications?_____

Who Prescribes Your Other Medications?_____

How Did You Hear About Us?

Signature or Title of the Person Actually Filling Out This Form_____

Relationship to Patient_____

Date When Form Filled Out_____

IF A LAWSUIT

Explain _____

Attorney Contact Information _____

Attorney Phone # _____

IF A MOTOR VEHICLE ACCIDENT

Explain _____

Give Date _____ Auto Carrier's Name _____

Claim# _____ Adjuster's Name _____

Adjuster Phone _____ Adjuster Fax _____

IF A WORKERS COMPENSATION CASE

Date of Injury _____ Circumstance of Injury (Explain) _____

Name of Work Comp Carrier _____

Name of Your Employer _____ Phone _____

Adjuster's Name _____

Adjuster's Address _____

Adjuster's Phone _____ Adjuster's Fax _____

Do You Have a Case Worker? Yes No or a QRC? Yes No

If Yes Who? _____ Phone _____ Fax _____

Address of Caseworker or QRC _____

INSURANCE INFORMATION

Primary Insurer _____ Secondary Insurer _____

Insurer Address _____ Sec. Insurer Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Policy/ ID# _____ Policy/ ID# _____

Group# _____ Effective Date _____ Group# _____ Effective Date _____

Policy Holder _____ DOB _____ Policy Holder _____ DOB _____

Your Employer's Name _____ Phone _____ Fax _____

Is a Referral Required for You to be Seen in Our Clinic? Yes No

NOTE: If Your Insurance Requires a Referral, and if Such is Not Provided, You Will be Responsible for the Payment of All Charges. All Co-payments are Due at the Time of the Appointment. You will also be responsible for any Deductibles determined by your Insurance Provider.

I Understand, and Confirm, That the Above Information is Accurate:

Patient Signature

Date