To help us with the consultation, please complete this Questionnaire (5 pages). It should take approximately 15 minutes. Thank you in advance & the information you provide is vital.
Please bring your reading glass.

Affix Patient Label

Date Completed : ……..

1. **Surname:** .....
2. **First Name :** ..... **Age:** .....Years **DOB:** ..... **Sex:** .....
3. **Mobile Number :** ..... **Email :** .....
4. **NHS** ☐ **Self Pay** ☐ **Insured** ☐ **Insurer Name:** ……

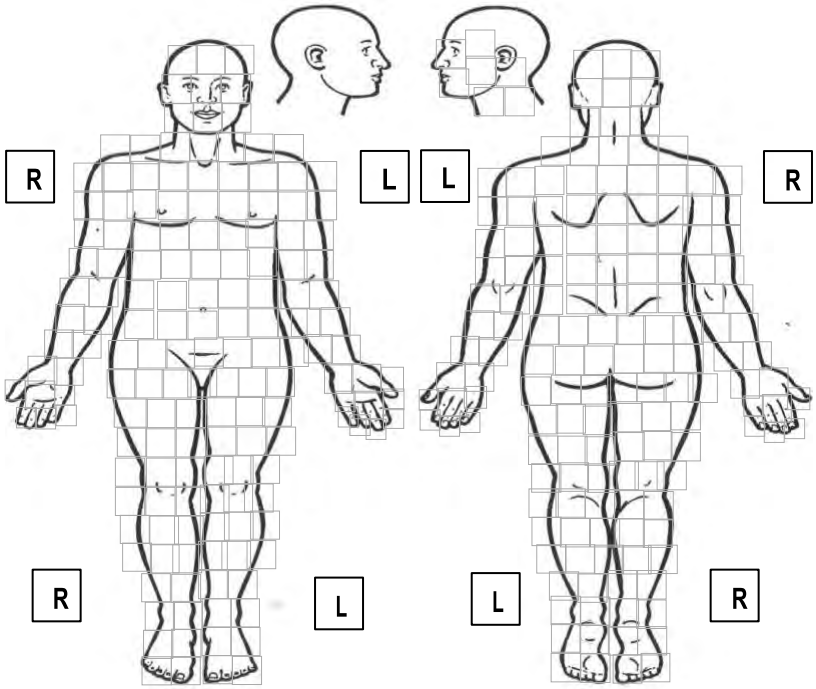
Private Patient only: Membership Number :…… **Authorisation Number:** .....

5. **Home address:** ……..……...
   ….…… **Land Line :** ……..……..……
6. **Occupation Present or Retired as :** .....; If Retired from when : ……..…..
   If Unemployed (from ……..……) / ☐ Student / ☐ Housewife ; ☐ Others : …….
7. **What percentage % of your work involves –** Heavy activities …….; Moderate Activities ……. ;
   Light Activities…….;Sitting…….;Standing…….;Travelling…..…; Driving…..…; Repetitive Bending & Twisting…..…
8. **If working – your status** ☐ Working in full capacity ☐ Working in full capacity but with limitation
   ☐ Working as light duties ☐ On Sick leave (from.....) ☐ Others .....
9. What are the concerns with your spine that has brought you to the clinic today? **(Circle the main concern)**
   ☐ Pain ☐ Pin & Needles ☐ Numbness ☐ Weakness ☐ Bladder problem (refer page 3)
   ☐ Reduced mobility & function ☐ Reduced walking distance ☐ Others.....

Your Pain related Questions - 10 to 25

10. **Where is your pain?**
    ☐ Low Back pain ☐ Upper back pain (Thorax) ☐ Neck Pain
    ☐ Pain in Lower limbs ☐ Pain to Upper limbs

11. ***Please indicate the area of pain distribution on the body diagram below & Table on the right - by clicking the box below OR mark with 'X' or circle**



Tick the box - Where the Pain is		
	Left	Right
Neck	☐	☐
Arm	☐	☐
Shoulder Blade	☐	☐
Elbow	☐	☐
Forearm	☐	☐
Hand	☐	☐
Thumb & Index Finger	☐	☐
Middle finger	☐	☐
Ring & Little finger	☐	☐
Buttock	☐	☐
Middle Back	☐	☐
Lower Back	☐	☐
Back of Thigh back	☐	☐
Hip / Front of thigh	☐	☐
Knee	☐	☐
Outer aspect of leg	☐	☐
Inner aspect of leg	☐	☐
Calf region	☐	☐
Ankle	☐	☐
Top of the foot	☐	☐
Sole of the foot	☐	☐
Big toe	☐	☐
Small toes	☐	☐

12. **Back pain or Neck pain -** On a score of 0 -10 where 0 is no pain and 10 is the worst pain imaginable, What would you score your average pain (A) and your worst pain (W) ?

Back pain (BP) - ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Neck pain (NP) - ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

13. How long have you had Back or Neck pain for?

Back pain - ☐ < 8 weeks ; ☐ 2 - 6 mths; ☐ 6 -12 mths; ☐ 1 to 2 yrs; ☐ Longer ____ yrs

Neck pain - ☐ < 8 weeks ; ☐ 2 - 6 mths; ☐ 6-12 mths; ☐ 1 to 2 yrs; ☐ Longer ____ yrs

14. **Lower limb** (Thigh / Leg / foot) **pain or Upper Limb** (Shoulder / Arm / Forearm / Hand) **pain -** On a score of 0-10 where 0 is no pain and 10 is the worst pain, what would you score average pain (A) and your worst pain (W)?

Lower Limb (LL) pain - ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Upper Limb (UL) pain - ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

15. How long have you had Lower limb (LL) pain or Upper limb (UL) pain for?

Lower Limb (LL) Pain - ☐ < 8 weeks; ☐ 2 - 6 mths; ☐ 6-12 mths ; ☐ 1 to 2 yrs; ☐ Longer ____yrs

Upper Limb (UL) Pain - ☐ < 8 weeks; ☐ 2 - 6 mths; ☐ 6-12 mths ; ☐ 1 to 2 yrs; ☐ Longer ____yrs

16. Which pain is worse - Back pain or Leg pain / Neck pain or Upper limb pain?

☐ **Back pain >** Leg pain ; ☐ Leg pain **>** Back pain ; ☐ Leg pain **=** Back pain

☐ **Neck pain >** Upper Limb pain ; ☐ Upper Limb pain **>** Neck pain; ☐ Upper Limb pain **=** Neck pain

17. How would you describe the pain?

Back Pain - ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Other _____

Neck Pain - ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Other _____

Lower Limb Pain – ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Other _____

Upper Limb Pain – ☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Other _____

18. What is the Duration of pain over all in a day?

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

19. Is the pain changing in intensity in the last few weeks ?

☐ Improving ☐ Staying the same ☐ Getting worse, if so from when - for the last …… weeks

20. Was the pain triggered by any specific events?

☐ Gradual onset; ☐ After Heavy Activity or after lifting heavy weight; ☐ Bending or twisting Activity;

☐ Following an accident, ☐ Other _____

Please provide details of the trigger episode ……

21. If you get pain on & off, how many episodes you get (Per months or year)? When was the last acute episode :

……

22. Do you get cramps, if so where & what brings it : ……

23. What activities increase your pain symptoms?

Sitting: ☐ Yes ☐ No If Yes after how long (in minutes) _____

Standing: ☐ Yes ☐ No If Yes after how long (in minutes) _____

Lying Down: ☐ Yes ☐ No If Yes after how long (in minutes) _____

Bending Forwards: ☐ Yes ☐ No ; Lifting weight: ☐ Yes ☐ No

Sneezing & Coughing: ☐ Yes ☐ No ; Any other specific activities: .....

24. What activities relieve the pain? .....

25. Does the pain wake you up from sleep or **disturb your sleep**?

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

Thank you for your patience

26. Is Walking distance Reduced? ☐ Yes ☐ No ; Do you lose balance when walking? ☐ Yes ☐ No
27. How long can you manage to walk in metres____ or in minutes_____ before symptoms arise in

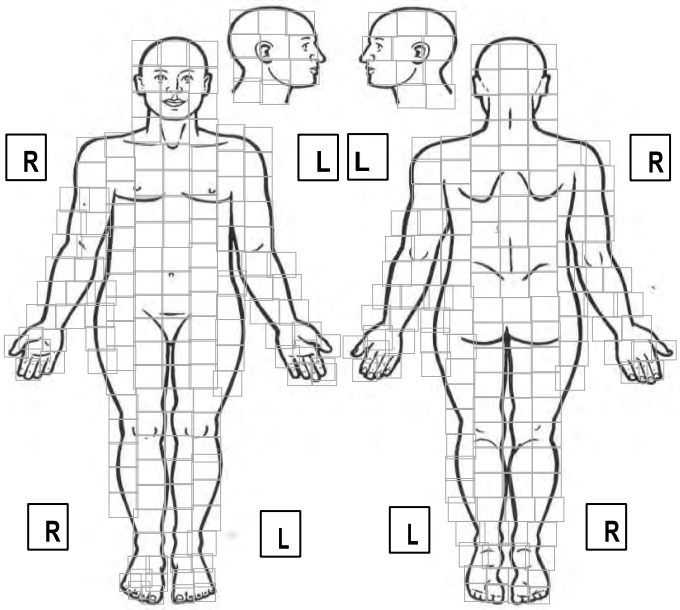
    ☐ Back ☐ Leg ☐ Both
28. Do you get pins and needles / Numbness in the Lower limbs (thighs / Legs / Foot) ? ☐ No ☐ Yes,

    if yes how long did you have it ____ weeks, further details ……
29. Do you get Weakness of the Lower limbs (Hip / Knee / Ankle / Toes) ? ☐ No ☐ Yes,

    if yes how long did you have it ____ weeks, further details ……
30. Do you get pins and needles / Numbness in the Upper limbs (Shoulder to Fingers)? ☐ No ☐ Yes,

    if yes how long did you have it ____ weeks, further details ……
31. Do you get Weakness in the Upper limbs (Shoulder to Fingers)? ☐ No ☐ Yes,

    if yes how long did you have it ____ weeks, further details ……
32. *** Please indicate the <u>area of Pins and Needles/ Numbness</u> on the body diagram below by clicking the box below or mark 'X' or a circle**



*****If your answer to the questions <u>number 33 below are YES</u>, it means you would require urgent assessment& treatment. Please go to A&E & request for an urgent assessment & treatment <u>within 6 to 12 hours</u>,** preferably in the nearby A & E or Tertiary spinal unit which has spinal on-call facilities (such as James Cook Uni Hosp, Royal Sunderland Hospital, RVI Newcastle, Leeds General Infirmary). As we are not a tertiary spinal unit, Mr Kalyan would not be able to provide urgent care. **<u>Please cancel your appointment with Mr Kalyan</u>** or if in doubt speak to your GP or my Private Secretary. It is your responsibility to obtain appropriate assessment & care.

33. ***Do you have any of the following RED FLAG SYMPTOMS OR SIGNS (requiring Urgent assessment), associated with your Spinal pain & symptoms, which are of recent onset**

	Yes, means Red flags, Go to A&E		Durations in days
a) Bladder incontinence, Bladder retention, Urinary urgency, Difficulty in initiation or passing water (other than long standing stress incontinence dueto old age / post childbirth; due to long standing Prostate problem, etc.)	☐ **Yes**	☐ No	
b) Incontinence of Bowel & Loss of Control of the Bowel	☐ **Yes**	☐ No	
c) Numbness in the Private parts/Back passage region	☐ **Yes**	☐ No	
d) Severe weakness - not due to pain, but due to reduced power to move the joints requiring wheelchair or walking aids OR Unable to move any major joints – such as hip, Knee, Ankle, Shoulder, elbow, Wrist, Fingers, etc.	☐ **Yes**	☐ No	
e) Sciatica pain in both legs	☐ **Yes**	☐ No	

Thank you for your patience

34. Have you had any other problems with bladder & How long? ☐ No ☐ Yes
☐ Bladder problem following childbirth or Hysterectomy surgery ☐ Stress Incontinence (age related
☐ Prostate problem / Surgery ☐ Bladder Prolapse ☐ Prostate problem / Surgery

Please provide further details (from when/ treatment received) below: ……..
……

35. Have you had any other problems with bowel & How Long? ☐ No ☐ Yes
☐ Constipation ☐ Irritable bowel disease ☐ Ulcerative Colitis / Crohns Disease ☐ Rectal prolapse
☐ Anal fissure/ Haemorrhoids ☐ Uterus prolapse

Please provide further details (from when/ treatment received) below: ……..
……

36. **Do you think any of your Bowel or Bladder problem is related to your spine problem?** ☐ No ☐ Yes
if Yes, please refer to question 33 & the advice provided for urgent care.

37. How much does your spinal problem stop you going to Work / College/ School?
☐ None of the time ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time

38. Do you do any recreational activities or Sports? ☐ No ☐ Yes
If Yes, please specify any high impact activities in the past _____

39. How much does your pain stop you from doing sports or overall activities?
☐ None of the time ☐ A little of the time ☐ Some of the time ☐ Most of the time

40. Have you been admitted to hospital or attended the A&E because of Spinal pain? ☐ No ☐ Yes
If yes, please provide details _____

41. Have you had any treatment for your spine problem? ☐ No ☐ Yes
☐ Chiropractic ☐ Osteopathy ☐ Physiotherapy ☐ Acupuncture ☐ Massage ☐ Pain Specialist
☐ Spinal injection ☐ Spinal Surgery ☐ TENS machine ☐ Others

Please provide further details (from when/ treatment received) below: ……
……
……

42. Do have significant medical problems? ☐ No ☐ Yes, If Yes, tick all that apply

Diabetes ☐	Asthma ☐	Kidney disease ☐	**Anxiety** ☐
High Blood Pressure ☐	**COPD** ☐	Liver failure ☐	**Depression** ☐
Heart attacks ☐	**Stroke / TIA** ☐	Gall bladder problem ☐	Migraine ☐
Angina ☐	Skin conditions ☐	Thyroid problems ☐	Claustrophobia ☐
Irregular heartbeat ☐	Aneurysm ☐	Prostate problem ☐	Fibromyalgia ☐
Pacemaker ☐	**Clot in the Lungs** ☐	Rheumatoid arthritis ☐	Drug overdose ☐
Heart Murmur ☐	**Clot in the legs** ☐	Gout ☐	**Long Covid** ☐
Peripheral Neuropathy ☐	Obstructive Sleep Apnea ☐	H/O Psoriasis ☐	☐
Osteopenia / Osteoporosis ☐	Peripheral vascular disease ☐	Heart Burn/ Gastric reflex ☐	Carpal tunnel syndrome ☐
Any Cancer _____			
Other Arthritis – Hip ☐ / Knee ☐ / Ankle ☐ / Toes ☐ / Shoulder ☐ / Elbow ☐ / Wrist ☐ / Fingers ☐			
Others (Please specify/ provide details of any significant medical problems) …….. …… ……			

Please bring with you for the consultation - any clinic letters or other information or Investigation (such as MRI, Nerve conduction study, Blood tests) about your previous spinal treatment or other treatment you had that may be relevant.

Thank you for your patience

43. What **Pain Medicine** do you take for spinal problem? ☐ No ☐ Yes as required ☐ Yes Regularly

Name	Dose / Frequency	Name	Dose / Frequency
Paracetamol ☐		Codeine ☐ Dihydrocodeine ☐	
Co - Codamol ☐ Codydramol ☐		Naproxen ☐	
Ibuprofen ☐ Diclofenac ☐		Nefopam ☐	
Tramadol ☐		Amitriptyline ☐ Duloxetine ☐	
Morphine ☐ MST ☐ Oxycontin ☐		Skin Patches ☐ Specify	
Gabapentin ☐ Pregabalin ☐		Diazepam ☐	
Tropical Ointment ☐		CBD ☐	
Others – More details ……			

44. Do you take any medicines regularly for other medical problems? ☐ No ☐ Yes

Name (**Please bring your prescription sheet)**	Dose	Frequency
1)		
2)		
3)		

45. Do you take any blood thinning medications? ☐ **No** ☐ Yes, if yes please tick a bow below and specify
☐ Aspirin ☐ Warfarin ☐ Clopidogrel ☐ Dabigatran (Pradaxa) ☐ Apixaban (Eliquis)
☐ Rivaroxaban (Xarelto) ☐ Others ; Why do you take it, Please provide details ……..
……
46. Do you take any immunosuppressant medications? ☐ No ☐ Yes, if yes please select a box below
☐ Steroids ☐ Methotrexate ☐ Chemotherapy agents ☐ Infliximab (Remicade)
☐ Etanercept (Enbrel) ☐ Adalimumab (Humira) ☐ Others ; Why do you take it, Please provide details ……
47. Have you any allergies? ☐ No ☐ Yes, if yes please provide details ……
……..
48. Did you have any surgery in the past & which year roughly? ☐ No ☐ Yes
☐ Spine ☐ Hip replacement ☐ Knee replacement ☐ Knee Arthroscopy ☐ Ankle ☐ Shoulder
☐ Carpel Tunnel ☐ Ulnar Nerve ☐ Hysterectomy ☐ Bowel ☐ Bladder ☐ Prostate ☐ Heart
☐ Gall Bladder removal ☐ Appendicectomy ☐ Cancer surgery ☐ Others
Please give details below of the year of the surgery or if selected 'Other': ……..
……...
49. Did you have problem with anaesthesia before? ☐ No ☐ Yes, If Yes please provide details below:
……
50. Do you smoke? ☐ No ☐ Yes, If Yes _____ number of cigarettes/day OR stopped in _____
51. Do you drink Alcohol? ☐ No ☐ Yes, If Yes_____number of units/week (rough measures - 1 pint of beer is 2 to 3 units, 1 medium glass of wine is 2 units, 25 ml of spirit is 1 unit)
52. Do you have any Intra-orbital foreign bodies, intra-cranial clips, cohlear implants, heart valve, Pacemaker, foreign objects or implants in the body & any recent surgery? ☐ No ☐ Yes, if yes please specify below:
……
53. (Female Patient only) Are you likely to be Pregnant? ☐ No ☐ Yes; Last Menstrual period_____
54. Do you wish to mention any other related matter not covered so far?
……
……
55. **GP Details/Address:**……..
……

Thank you for your patience