

To help us with the consultation, please complete this Questionnaire (4 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. GP Details: .....

7. Occupation now or Retired as : .....; Unemployed (from.....) / Student / Housewife

8. What percentage % of your work involves – Heavy activities .....; Moderate Activities .....; Light Activities.....;Sitting.....;Standing.....;Travelling.....; Driving.....; Repetitive Bending & Twisting.....

9. If working – your status Working in full capacity Working in full capacity but with limitation  
Working as light duties On Sick leave (from.....) Others .....

10. What are the concerns with your spine that has brought you to the clinic today? **(Circle the main concern)**

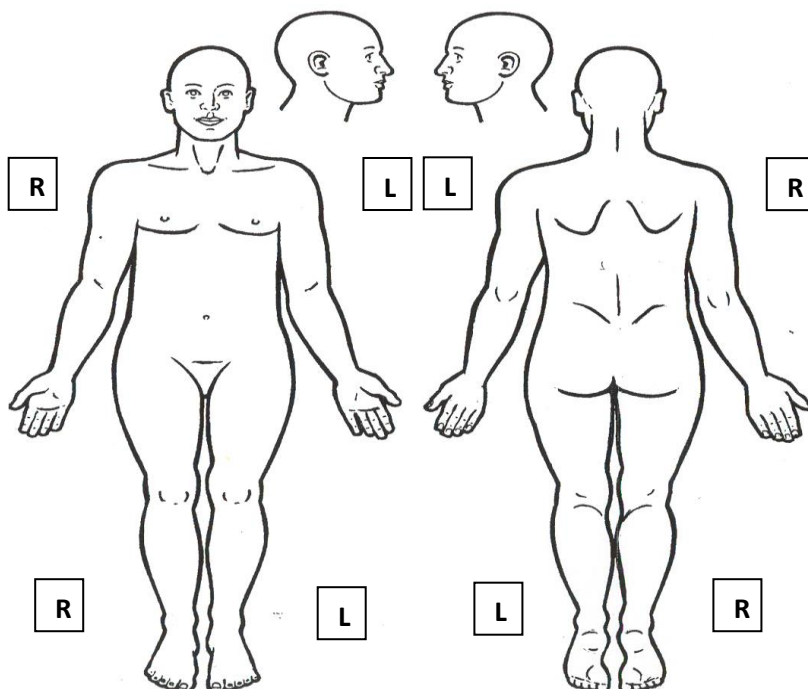
Pain Pin & Needles Numbness Weakness Bladder problem (refer page 3)  
Reduced mobility & function Reduced walking distance Others.....

**Pain**

11. Where is your pain?

Low Back pain Upper back pain (Thorax) Neck pain  
Pain in Lower limbs Pain to Upper limbs

12. Please click the box to indicate the area of pain distribution on the body diagram below



Circle the region - Where the Pain is		
	Right	Left
Arm		
Elbow		
Forearm		
Hand		
Thumb & Index Finger		
Middle finger		
Ring & Little finger		
	Right	Left
Buttock		
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		

13. **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) ?

<b>Back pain (BP) -</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Neck pain (NP) -</b>	0	1	2	3	4	5	6	7	8	9	10

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

<b>Back pain -</b>	< 6 weeks ;	3 - 6 mths;	6-12 mths;	1 to 2 yrs;	Longer ____ yrs
<b>Neck pain -</b>	< 6 weeks ;	3 - 6 mths;	6-12 mths;	1 to 2 yrs;	Longer ____ yrs

15. **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 and your worst pain?

<b>Lower Limb (LL) pain -</b>	0	1	2	3	4	5	6	7	8	9	10
<b>Upper Limb (UL) pain -</b>	0	1	2	3	4	5	6	7	8	9	10

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

<b>Lower Limb (LL) Pain -</b>	< 6 weeks;	3 - 6 mths;	6- 12 mths ;	1 to 2 yrs;	<input type="checkbox"/> Longer ____ yrs
<b>Upper Limb (UL) Pain -</b>	< 6 weeks;	3 - 6 mths;	6-12 mths ;	1 to 2 yrs;	Longer ____ yrs

17. 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

18. How would you describe the pain?

<b>Back or Neck Pain -</b>	Aching	Throbbing	Stabbing	Burning	Other _____
<b>Lower Limb or Upper Limb Pain -</b>	Aching	Throbbing	Stabbing	Burning	Other _____

19. 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

20. Is the pain changing in intensity in the last one months?

- Improving     Staying the same     Getting worse

21. Did the onset of pain coincide with any event?

- Gradual onset;  After Heavy Activity or after lifting heavy weight;  Bending or twisting Activity;
- Following an accident, Please specify \_\_\_\_\_ ,  Other \_\_\_\_\_

22. 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 ;    Others : .....

23. What activities relieve the pain? .....

24. 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

25. Is Walking distance Reduced?  Yes  No ; Do you lose balance when walking?  Yes  No

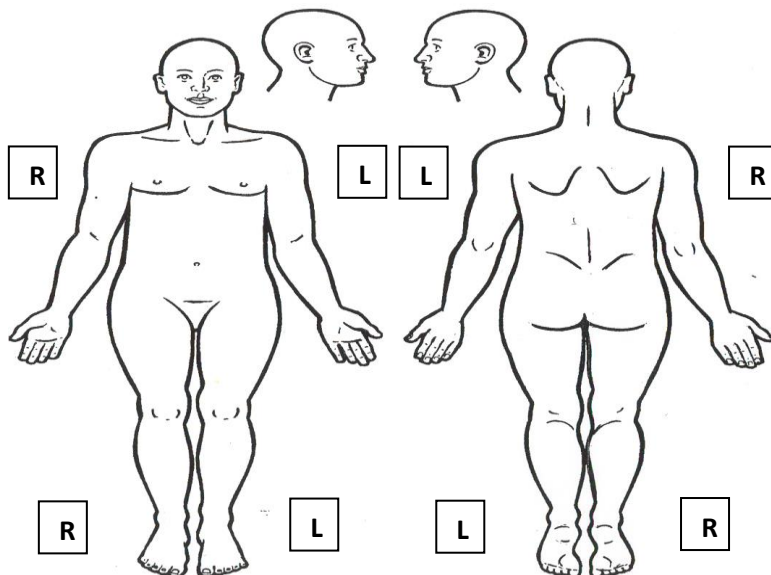
26. How long can you manage to walk in metres \_\_\_\_\_ or in Minutes \_\_\_\_\_ before symptoms arise in

- Back     Leg     Both

27. 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

28. Do you get pins and needles / Numbness in the Lower limbs?  Yes  No , How long \_\_\_\_\_
29. Do you get Weakness of the Lower limbs ?  Yes  No , How long \_\_\_\_\_
30. Do you get pins and needles / Numbness in the Upper limbs ?  Yes  No , How long \_\_\_\_\_
31. Do you get Weakness in the Upper limbs ?  Yes  No , How long \_\_\_\_\_
32. Please click on the box to indicate the area of Pins & Needle and Numbness in the diagram below



If your answer to the questions number 33 below are YES, it means you would require urgent assessment & treatment. Please go to A&E & request for an urgent assessment & treatment within 6 to 12 hours, 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. **Please cancel your appointment with Mr Kalyan** 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
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
a) Bladder incontinence, Bladder retention, Urinary urgency, Difficulty in initiation or passing water (other than long standing stress incontinence due to old age / post childbirth; due to long standing Prostate problem, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) Incontinence of Bowel & Loss of Control of the Bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c) Numbness in the Private parts/Back passage region	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
e) Sciatica pain in both legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

34. Have you had any other problems with bladder & How long ?  No,  Stress Incontinence (age related),  Bladder problem following childbirth or Hysterectomy surgery  Prostate problem / Surgery  Bladder Prolapse,  Bladder Surgery \_\_\_\_\_; From When \_\_\_\_\_, what treatment so far? \_\_\_\_\_
35. Have you had any other problems with bowel & How Long ? No, Constipation, Irritable bowel disease,  Ulcerative Colitis / Crohns Disease Rectal prolapse Anal fissure / Haemorrhoids  Uterus prolapse; From When & What treatment so far \_\_\_\_\_
36. Do you think any of your Bowel or Bladder problem is related to your spine problem? No,  Yes \_\_\_\_\_
37. Do you do any recreational activities or Sports? No If Yes, please specify \_\_\_\_\_
38. 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

39. Have you been admitted to hospital or attended the A&E because of Spinal pain?

- No  Yes (please provide details) \_\_\_\_\_

40. Have you had any treatment for your spine problem?

- Chiropractic,  Osteopathy,  Physiotherapy,  Acupuncture,  Massage  Pain Specialist,  
 Spinal injection,  Spinal Surgery,  TENS machine,  None so far,  Others Please specify \_\_\_\_\_

41. Do have significant medical problems?  No  Yes If Yes

- Diabetes**  High Blood Pressure  **Heart attacks**  **Angina**  **Irregular heart beat**  **Pacemaker**  
 Heart Murmur  Asthma  **COPD**  Heart Burn  Thyroid problems  Kidney failure  
 Liver failure  Prostate problem  Bowel or Gall bladder problem  Rheumatoid arthritis  
 Other Arthritis – Hip / Knee / Ankle / Shoulder / Elbow / Wrist / Fingers  Gout  Fibromyalgia  
 Osteopenia / Osteoporosis  Peripheral Neuropathy  Carpal tunnel Syndrome  Aneurysm  
 Peripheral vascular disease  **Clot in the legs**  **Clot in the Lungs**  **Depression**  **Anxiety**  
 Migraine  Drug overdose or recreational drugs  Claustrophobia  **Cancer** \_\_\_\_\_

Others Please specify \_\_\_\_\_

42. What **Pain medicine** do you take for the 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		Other(please state)	

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

Name ( <b>Please bring your prescription sheet</b> )	Dose	Frequency
1)		
2)		
3)		

44. Do you take any blood thinning medications?  **No**  Aspirin  Warfarin  Clopidogrel  
 Dabigatran (Pradaxa),  Apixaban (Eliquis),  Rivaroxaban (Xarelto)  Others .....

45. Do you take any immunosuppressant medications? For eg. - Steroids, Methotrexate, other Chemotherapy agents, anti-TNF treatment like infliximab (Remicade), etanercept (Enbrel), or adalimumab (Humira). **No Yes**

46. Have you any allergies?  No  Yes (please state) \_\_\_\_\_

47. Did you have any surgery in the past & which year roughly?  Spine  Bowel  Bladder  
 Hysterectomy Prostate Hip replacement Knee replacement Knee Arthroscopy Shoulder  
 Ankle Heart Others Please give details \_\_\_\_\_

48. Did you have problem with anaesthesia before?  No  Yes If Yes \_\_\_\_\_

49. Do you smoke?  No  Yes If Yes \_\_\_\_\_ number of cigarettes/day OR Stopped in \_\_\_\_\_

50. 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)

51. Do you have any Intra-orbital foreign bodies, intra-cranial clips, cochlear implants, heart valve, Pacemaker, foreign objects or implants in the body & any recent surgery?  No  Yes If Yes \_\_\_\_\_

52. (Female Patient only) Are you likely to be Pregnant?  No  Yes ; Last Menstrual period \_\_\_\_\_

53. Do you wish to mention any other related matter not covered so far?  
 \_\_\_\_\_