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 : ……………………………………………...

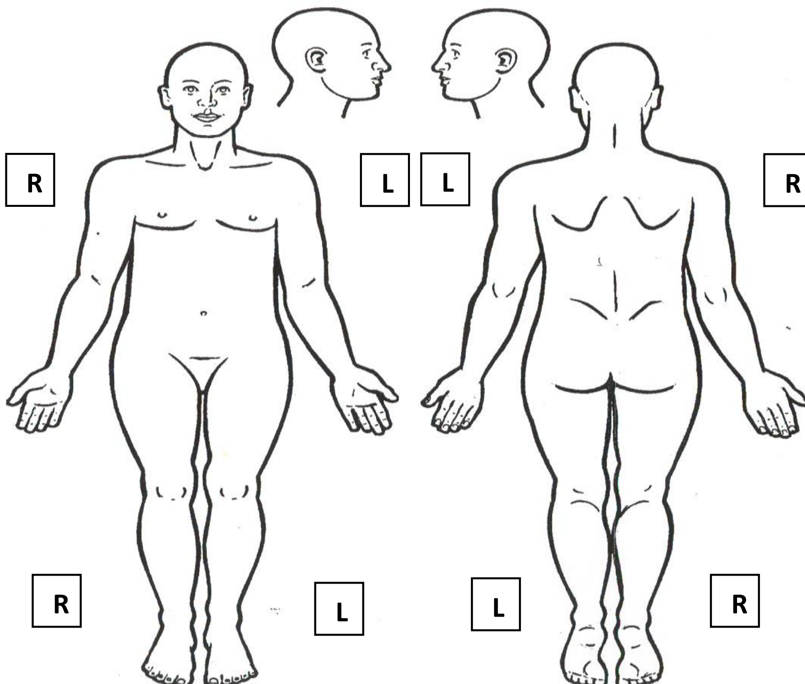
1. **Surname:** ....
2. **First Name :** .... **Age:** ....Years **DOB:** .... **Sex:** F / M / Other
3. **Mobile Number :** .... **Email :** ....
4. **NHS / Self Pay / Insured /** ……………………..… **Insurer Name:** ………………………………………………

<u>Private Patient only</u>: Membership Number :……………………… A**uthorisation 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.....................................

<u>Pain</u>

11. **Where is your pain?**
Low Back pain □ , Upper back pain (Thorax) □ , Neck pain □
Pain in Lower limbs □ , Pain to Upper limbs □
12. **Please mark 'X' symbol for the <u>area of pain distribution</u> in 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) ?

    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

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

    Back pain - □ < 6 weeks ; □ 3 - 6 mths; □ 6-12 mths; □ 1 to 2 yrs; □ Longer ____ yrs

    Neck pain - □ < 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?

    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

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

    Lower Limb (LL) Pain - □ < 6 weeks; □ 3 - 6 mths; □ 6-12 mths ; □ 1 to 2 yrs; □ Longer ____ yrs

    Upper Limb (UL) Pain - □ < 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?

    Back or Neck Pain - □ Aching □ Throbbing □ Stabbing □ Burning □ Other _____________

    Lower Limb or Upper Limb Pain - □ 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

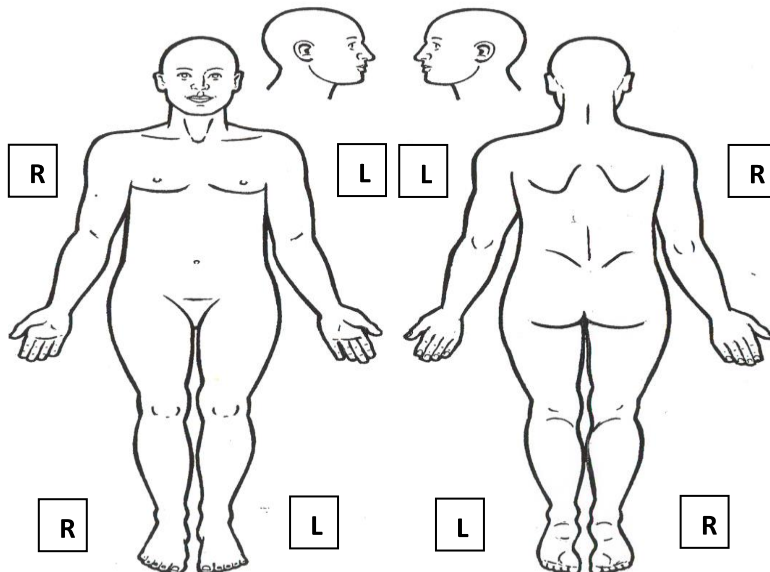
25. Is Walking distance Reduced? □ Yes □ No ; Do you lose balance when walking? □ Yes □ No

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 mark '✚' symbol for the <u>area of Pin & Needle</u>, "-" for <u>area of Numbness</u> in the diagram below**



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 due to 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	

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 □ All 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 or Dihydrocodeine	
Co-Codamol / Codydramol		Naproxen	
Ibuprofen or Diclofenac		Nefopam	
Tramadol		Amitriptyline or Duloxetine	
Morphine or MST or Oxycontin		Skin Patches – Specify	
Gabapentin or Pregabalin		Other (please state)	

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

Name (**Please bring your prescription sheet**)	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, cohlear 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?
    ____

Thank you for your patience