THOMAS J HOPKINS PH.D., M.D.
DIPLOMAT AMERICAN BOARD OF ORTHOPAEDIC SURGEONS
SURGERY / DISORDERS
CERVICAL, THORACIC, LUMBOSACRAL SPINE

Personal Injury Questionnaire

Name _____

Email: _____

Today's Date: _____/_____/ _____

Date of Injury: _____/_____/_____

Name of Attorney: _____

Phone Number (____) _____

Email _____

Auto Insurance Information (If applicable):

Insurance Carrier_____

Phone Number (____) _____

Auto Claim Number _____

Policy Holder _____

If an interpreter accompanies you, it is important for the proper identification of the person verifying your signature:
(If you have a business card please have the front desk attach it to this form)

Translator/Interpreter Name: _____

Address _____

City: _____

State _____

Zip _____

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Dear Patient:

Attached is a questionnaire designed to provide the information needed for a comprehensive evaluation of your particular spine problem. Some questions are concerned with your social situation as well as your physical condition. Understanding of both these areas are important for diagnosis and comprehensive patient care. You are not asked to answer any questions that you consider inappropriate. We would appreciate you fully answering the questions with the appropriate information rather than providing answers such as "see file". Please take the time to fully complete the entire form / all of the questions to the best of your ability. It is imperative that you list your Internist (please see the next page).

Thank you for completing this questionnaire.

Please explain why you have come to us and what you would like us to do for you

(Please limit your discussion to this page, ***being as specific as possible***).

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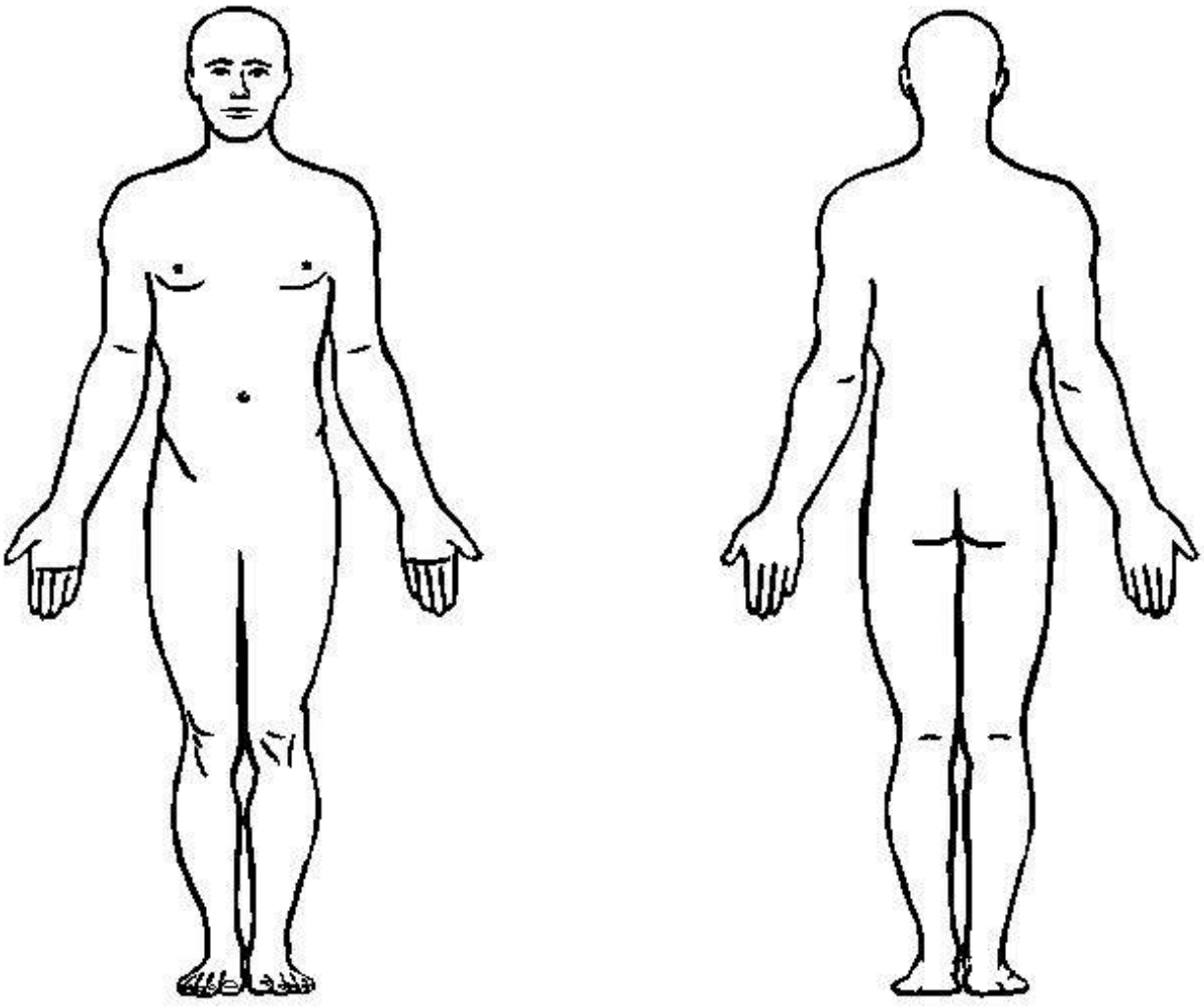
Please mark the areas on the diagram below where you feel the described sensations on your body. Please use the appropriate symbol. Please mark the areas in which you experience pain (including areas of radiating pain). Please include all affected areas.

Numbness: (===)
Pins and Needles: (000)
Burning: (XXX)
Stabbing: (///)
Ache: (###)



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Spine Pain Questionnaire:

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Telephone: (_____)_____

Birth date: _____/_____/_____

Age: _____

Occupation: _____

Right or Left Handed? _____

Referring Physician: _____

Internist (required):

Name: _____

Address _____

_____

City: _____

Zip: _____

Phone Number: (____) _____

Fax Number: (____) _____

Email: _____

Attorney (required):

Name: _____

Address _____

_____

City: _____

State: _____

Zip: _____

Phone Number: ( ) _____

Fax Number: ( ) _____

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Email: _____

THE ACCIDENT: (Circle One)

If you were in a vehicle accident which side of the car was hit? Driver's side Passenger side

Where was the vehicle hit from? _____

What type of vehicle were you driving? _____

What type of vehicle hit you? _____

How fast were you going? _____

How fast was the other vehicle going? _____

Did you lose track of what was going on at the time of the accident? **Y** **N**

If **YES** please explain _____

_____

Did your head hit anything at the time of the accident? **Y** **N**

If **YES** please explain? _____

_____

Did airbags deploy? **Y** **N**

Did you have seat belts on? **Y** **N**

Were you the driver? **Y** **N**

Were you the passenger? **Y** **N**

Where were you in the vehicle? (Circle One) **Front seat** **Back seat**
Passenger side **Driver side**

After the accident did you get yourself out of the vehicle? **Y** **N**

If **NO** please explain _____

Did an emergency medical team take you to the hospital? **Y** **N**

Name of hospital _____

What Diagnosis has been given as the cause of your pain? _____

Please circle if you had any of the following: CT Scan MRI X-Ray Other_____

How long were you in the hospital? _____

Were you admitted into the hospital? **Y** **N**

If **YES** how many days _____

Were any procedures performed? **Y** **N**

Please explain: _____

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Did you go to an **ER/Urgent Care Center/Family Physician** after the accident? **Y** **N**

If **YES** please give the approximate date and facility**.** Date: _____

Facility: _____

Do you have headaches since the accident? **Y** **N**

IF YOU WERE HOSPITALIZED FOR YOUR CONDITION WITHOUT HAVING AN OPERATION:

Date: _____ How many days in the hospital? _____

If you have had a Spinal Operation:

Date:_____

Type of Surgery (Include level if possible):_____

Amount of Improvement: (Circle One) **Complete** **Partial** **None**

Duration of Improvement: _____

Did you return to work? **Y** **N**

IF YOU HAVE BOTH NECK AND ARM PAIN:

Have you had previous similar troubles with your neck and/or arm pain before the accident? **Y** **N**

A) What caused the symptoms? _____

Please Circle: Work Related **Personal Injury** **Other** _____

Approximate Beginning Date: _____ Approximate End Date _____

Did the prior symptoms resolve completely before this accident? **Y** **N**

B) If yes, are the current symptoms similar to the symptoms before the accident? **Y** **N**

How are the symptoms different? _____

_____

What percentage of your total pain is in your **NECK?** _____**%**

When did the **NECK** pain start? At the time of the accident or after the accident? How long after? _____

What percentage of your total pain is in your **ARM?** _____**%**

When did the **ARM** pain start? Date:_____

Percent in your right arm _____%

Percent in your left arm: _____%:

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Is your Arm, Wrist or Hand weak? **Y** **N**

Is the pain constant during the entire day? **Y** **N**

How long does the pain last at any one time? _____ Minutes _____Hours

Do you have pain every day? **Y** **N**

Treatments:

What treatments have you had, please circle what applies:

Epidurals How many treatments? _____ Date: _____to_____

Physical Therapy PT How many treatments? _____ Date: _____to_____

Chiropractic How many treatments? _____ Date: _____to_____

Accupuncture How many treatments? _____ Date: _____to_____

Are you currently having treatment? (Circle**)** **Epidurals** **PT** **Chiropractic** **Accupuncture**

NECK PAIN:

How severe is your **NECK** pain? (PLEASE CIRCLE THE APPROPRIATE NUMBER)

(No Pain) (Moderate Pain) (Severe Pain)

1 2 3 4 5 6 7 8 9 10

Circle any of the following activities that make the neck pain worse.

Sitting	Standing	Walking	Running	Lying Down
Putting on Shoes	Driving a car	Riding in a car	Riding in a plane	Coughing
Sneezing	Bringing head back	Bringing head forward	Turning Right	Turning Left

Others please list _____

_____

_____

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Circle any of the following activities that relieves (partially or totally) the neck pain.

Sitting	Standing	Walking	Running	Lying Down
Rest	Heat	Massage	Exercise	Brace/Corset
Manipulations	Hot-Baths	TENS-Unit	Bringing head back	
	Bringing head forward	Turning Right	Turning Left	

Others please list _____

Does your neck pain awaken you from sleep? **Y** **N**

If yes approximately what date did this begin? Date: _____

ARM PAIN:

How severe is your **ARM** pain?

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

(No Pain) (Moderate Pain) (Severe Pain)

1 2 3 4 5 6 7 8 9 10

Circle any of the following activities that make the arm pain worse.

Sitting	Standing	Walking	Running	Lying Down
Putting on Shoes	Driving a car	Riding in a car	Riding in a plane	Coughing
Sneezing	Bringing head back	Bringing head forward	Turning Right	Turning Left

Others please list _____

Circle any of the following activities that relieves (partially or totally) the arm pain.

Sitting	Standing	Walking	Running	Lying Down
Rest	Heat	Massage	Exercise	Brace/Corset
Manipulations	Hot-Baths	TENS-Unit	Bringing head back	Bringing Head forward
Turning Right	Turning Left			

Others please list _____

Does your arm pain awaken you from sleep? **Y** **N**

If yes approximately what date did this begin? Date:_____

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BACK AND LEG SYMPTOMS:

Have you had previous similar troubles with your back and/or leg pain before the accident? **Y** **N**

A) What caused the symptoms? _____

Please Circle: Work Related **Personal Injury** **Other** _____

Approximate Beginning Date: _____ Approximate End Date _____

Did the prior symptoms resolve completely before this accident? **Y** **N**

B) If yes, are the current symptoms similar to the symptoms before the accident? **Y** **N**

How are the symptoms different? _____

_____

What percentage of your total pain is in your **BACK?_____%**

When did the **BACK** pain start? **At the time of the accident or after the accident?** How long after? _____

What percentage of your total pain is in your **LEG?_____%**

When did the **LEG** pain start? Date:_____

Percent in your right **LEG** _____%

Vs

Percent in your left **LEG:** _____%:

Did the symptoms come on (Circle One) **Gradually** or **Suddenly**?

Is your LEG, ANKLE or FOOT weak? **Y** **N**

Is the pain constant during the entire day? **Y** **N**

How long does the pain last at any one time? _____ Minutes _____Hours

Do you have pain every day? **Y** **N**

Treatments:

What treatments have you had, please check what applies:

Epidurals How many treatments? _____ Date: _____to_____

Physical Therapy PT How many treatments? _____ Date: _____to_____

Chiropractic How many treatments? _____ Date: _____to_____

Accupuncture How many treatments? _____ Date: _____to_____

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Are you currently having treatment? **Y** **N**

If YES where? _____

Doctor: _____

BACK PAIN ONLY:

How severe is your **BACK** pain?

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

(No Pain) (Moderate Pain) (Severe Pain)

1 2 3 4 5 6 7 8 9 10

Have you had Back pain before the accident? **Y** **N**

Do you have pain every day? **Y** **N**

Is the pain constant during the entire day? **Y** **N**

If **YES** when? _____

How long does the pain last at any one time? Minutes_____ Hours_____

What was the cause? _____

Circle any of the following activities that make the back pain worse.

Sitting	Standing	Walking	Running	Lying Down
Putting on Shoes	Driving a car	Riding in a car	Riding in a plane	Coughing
Sneezing				

Others please list _____

_____

Circle any of the following activities that relieves (partially or totally) the back pain.

Sitting	Standing	Walking	Running	Lying Down
Rest	Heat	Massage	Exercise	Brace/Corset
Manipulations	Hot-Baths	TENS-Unit		

Others please list _____

Does your back pain awaken you from sleep? **Y** **N**

If yes approximately what date did this begin? Date:_____

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LEG PAIN:

How severe is your **LEG** pain?

(PLEASE CIRCLE THE APPROPRIATE NUMBER)

(No Pain) (Moderate Pain) (Severe Pain)

1 2 3 4 5 6 7 8 9 10

Do you have pain every day? **Y N**

Is the pain constant during the entire day? **Y N**

If **YES** when? _____

How long does the pain last at any one time? Minutes_____ Hours_____

What was the cause? _____

Circle any of the following activities that make the leg pain worse.

Sitting	Standing	Walking	Running	Lying Down
Putting on Shoes	Being in a car	Riding in a plane	Coughing	Sneezing
Bending Forward	Bending Backward	Twisting		

Others please list _____

_____

Circle any of the following activities that relieves (partially or totally) the leg pain.

Sitting	Standing	Walking	Running	Lying Down
Rest	Heat	Massage	Exercise	Brace/Corset
Manipulations	Hot-Baths	TENS-Unit		

Others please list _____

_____

Does your leg pain awaken you from sleep? **Y N**

If yes approximately what date did this begin? Date:_____

Is your **LEG** or ankle weak? **Y N**

Do you walk normally? **Y N**

How far could you walk before the injury? (Circle One)

Less than one block Less than two blocks Less than three blocks

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How far can you walk now? (Circle One)

Less than one block Less than two blocks Less than three blocks

If you have pain after walking what do you do to relieve it? _____

_____

Have you ever had pain in your joints? **Y** **N**

Have you noticed any unexplained weight loss? **Y** **N**

If **YES**, how much and over what period of time? _____

Do you have a fever? **Y** **N**

Have you experienced night sweats? **Y** **N**

What tests have you had, please check what applies:

_____X rays Approximate Date: _____

_____Myelograms Approximate Date: _____

_____CT-Scans Approximate Date: _____

_____MRI Scans Approximate Date: _____

Prior History:

List all **NON SPINAL OPERATIONS** and the year that they were done and reason for the surgery.

1._____ Date: _____ Reason: _____

2. _____ Date: _____ Reason: _____

3._____ Date: _____ Reason: _____

List all **significant illnesses or diseases** other than minor colds and common childhood diseases.

1. _____

2. _____

3. _____

Do You Have A History of **Substance Abuse**? If Yes Please Explain: **Y** **N**

_____

_____

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List All Medication ***(PLEASE BE CERTAIN TO NAME THE MEDICATIONS WITH THE CORRECT SPELLING)*** that You Now Take, Including Narcotic Pain Medications, Please Be Sure to List the **Dosage** ***(PLEASE BE CERTAIN TO LIST THE DOSE AS WELL AS THE UNITS OF MEASUREMENT FOR THE DOSE - FOR EXAMPLE "MG")*** and **How Many Times a Day** You Take the Medication(s)

Name of Medication Dose/Strength How Often Taken

1._____

2._____

3._____

List All Allergies or Bad Reactions to Medications: ***(PLEASE NOTE THE PARTICULAR REACTION TO THE LISTED MEDICATION)***

Name of Medication Dose Amount / Frequency

1._____

2._____

3._____

Marital Status: (Check One)

Single:_____ Married:_____ Widowed:_____ Divorced:_____

Spouse's Age:_____

Number of Children:_____

Education: List Last Grade Attended in:

Grade School: ____

High School: ____

Vocational School: ____

Technical School: ____

College (Years Completed): ____

Graduate Education: ____

Are You Currently Employed? **Y** **N**

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Is Your Employment Part Time:_____ Full Time:_____ Hours per Week:_____

Please describe your current job. _____

_____

Do You Currently Smoke? **Y** **N**

If You Answered **NO** But Used To Smoke, When Did You Quit? Date: _____

Have you been involved in any Lawsuits involving Physicians?: **Y** **N**

The following general medical information will help your Physician. Please read through it and circle any symptoms that you have.

Eyes: Pain, Burning, Double Vision

Ears: Pain, Ringing, Loss of Hearing

Nose: Chronic Discharge, Nosebleeds

Mouth: Dry, Chronic Sores

Chest: Pain, Cough, Shortness of Breath with Normal Activity, Shortness of Breath in Bed, Heart Palpitations

Breasts: Masses, Discharge

Abdomen: Pain, Need to Avoid Certain Foods Cramps, Diarrhea, Constipation, Change in Stool

Urine: Burning on Urination, Change in Color or Nature of Urine

Do You Have Difficulty Either Starting or Holding Your Urine? **Y** **N**

Do you Need to get up at Night to Urinate? **Y** **N**

If **YES**, has the number of times that you need to get during a night changed in the last year? **Y** **N**

Number of times per night? _____

If **YES**, has the number of times changed in the last six months?

Number of times per night? _____ **Y** **N**

Do you ever have a loss of control (even slight): during the day? **Y** **N**

Do you ever experience a loss of control when you cough or laugh? **Y** **N**

Do you have a Urologist? **Y** **N**

Urologist Name: _____

Address: _____

City: _____

Zip Code: _____

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Date Last visited:_____

Have you had any urological / prostate surgeries? **Y** **N**

Date: _____

Diagnosis: _____

Musculoskeletal: Pain or Swelling in any Joints, Pain with Change in Weather? **Y** **N**

Other: Headaches, Loss of Energy, Unintentional Loss of Weight, Change in Appetite, Difficulty Sleeping, Change in Skin, Depression, Thoughts of Suicide, Desire to see a Psychiatrist, Difficulty in Tolerating Heat or Cold

For Women: Date of Last Menstrual Period: _____

Any Menstrual Irregularities: _____

Are you pregnant? _____

Medical History

(All Responses Will Be Maintained in Strict Medical Confidence)

Yes No (Please Check)

□ □ Have you ever taken clotting factor concentrate for a bleeding problem, such as Hemophilia?

□ □ Do you have AIDS or have you had a positive test for the AIDS Virus?

□ □ In the past 12 Months have you had sex with anyone who has AIDS or has tested positive for the AIDS Virus?

□ □ Have you ever had yellow jaundice or liver disease?

□ □ Have you ever had Hepatitis or a positive test for Hepatitis?

□ □ In the past 12 months have you been in close contact with a person with yellow jaundice or Hepatitis?

□ □ In the past 12 months have you been given Hepatitis B Immune Globulin (HBIG)?

□ □ In the past 12 months have you received a blood transfusion or had an organ or tissue transplant?

□ □ Have you ever been refused as a blood donor or told not to donate blood?

□ □ Do you have a Cardiac Pacemaker?

□ □ Do you have an implanted spinal cord simulator?

□ □ Do you have or had an implanted pain pump?

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