DR ANIL NAIR
Spinal Surgeon
BMed, FRACS

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Practice Locations:
Sydney|Western Sydney
Miranda | South Coast

Name

Age

Occupation

Left hand dominant Right hand dominant Ambidextrous

Previous spinal surgery (Include date, procedure, Surgeon, results and/or complications)

List your primary symptoms in order of importance (ie low back pain, neck pain, arm/leg weakness, sensation changes, imbalance etc)

1.
2.
3.
4.

Duration of symptoms and indicate precipitant if applicable

Precipitant of symptoms (ie was there an injury)

Do you have any of the following symptoms (if yes , please write location, severity, pertinent details)

Weakness (i.e foot drop)
Numbness
Pins & Needles
Balance Impairment
Gait disturbance (ie limping, leaning forward, etc)
Bowel Bowel or bladder dysfunction

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Pain Profile

Where is your pain now?

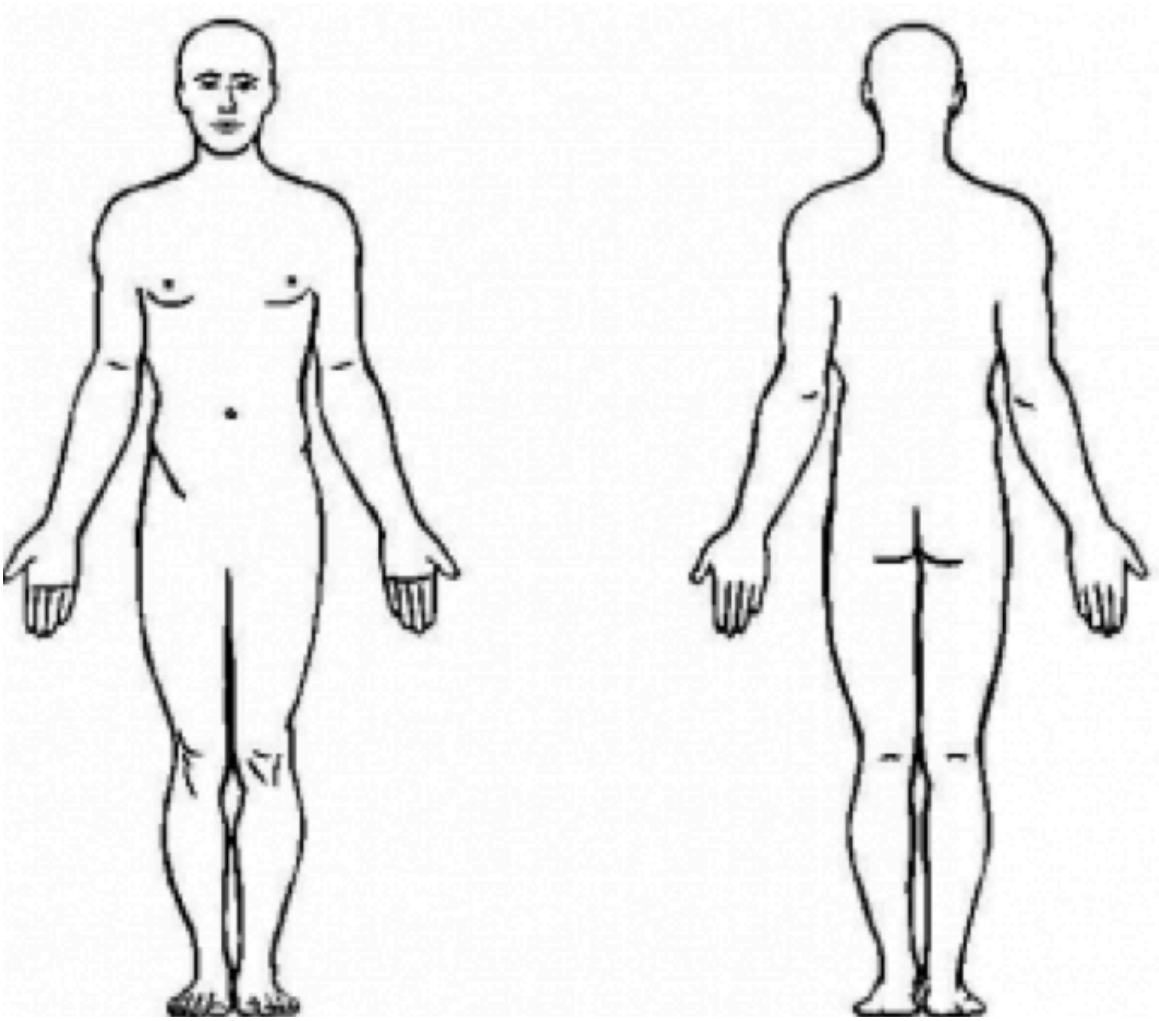
• Mark the areas on you body where you feel the sensations described below, using the appropriate symbol.

• Mark the areas of radiation and include all affected areas.

Aching>>>> , Numbness====, Pins/Needles III, BurningXXXX, Stabbing////

Front **Back**

Right **Left** **Left** **Right**



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Please rate your current pain on a scale of 0-10, with 0 being no pain and 10 being so severe that you could not live with it for more than a few minutes

Back	Right Buttock/leg	Left Buttock/Leg
Neck	Right Arm	Left Arm

What position or activity provokes your pain to the greatest degree

Which of the following aggravate your pain? (Please circle answers)

Sitting YES / NO	Standing YES / NO	Walking YES / NO
Driving YES / NO	Lying flat on back YES / NO	
Lying flat on stomach	YES / NO	
Lying on side if so which side	RIGHT / LEFT	
Changing positions (ie rising from sitting to standing, rolling over in bed)		YES / NO
Bending (ie brushing teeth over sink)		YES / NO
Pushing an object (ie heavy door, vacuum cleaner)		YES / NO
Coughing, sneezing, bearing down (Valsalva)		YES / NO
Do your symptoms affect your ability to fall or stay asleep?		YES / NO

Which of the following improves your pain

- Rest
- Bending forward ie leaning on a shopping trolley or walker
- Hydotheraphy
- Pain killers, if so please list
- Physiotheraphy
- Corticosteroid injections

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Are symptoms worse at a particular time of day? ***If so when***

Upon rising in the morning	YES / NO
At the end of the day	YES / NO
During the night	YES / NO

Is your condition

Getting worse	YES / NO	Getting better since initial onset	YES / NO
The same over time	YES / NO		

Joint Profile

- Describe if you experience any sudden "catching pain or locking of joints
- Please describe any if other joints are symptomatic
- Do you suffer from grinding of joints
- Do you suffer from stiffness of joints

Functional Profile

- Please quantify the following, in **time or distance:**
  - Sitting tolerance
  - Standing tolerance
  - Walking tolerance

- Do you have difficulties with the following tasks
  - Fine motor function ie knitting, buttons
  - Frequent dropping of objects

- Are you able to
  - Undertake all your chosen hobbies
  - Continue employment
  - Continue domestic task
  - Sleep undisturbed
    - If not how many time do you wake with pain

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Treatment Profile

Have you ever had any of the following treatments for these symptoms (Include dates, number of sessions, injections,etc and please indicated if these were helpful)

- Epidural Steriod Injections
- Facet Injections
- Trigger Point Therapy
- Physiotherapy
- Chiropractic Care
- Acupuncture
- Oral Steroids (ie Prednisone, Medrol 6-day pack)
- Other Treatments (Please describe)
- List tests taken and dates
    - X-rays
    - MRI,
    - CT,Myelogram,
    - Discogram,
    - EMG,
    - Bone Scan

Any history of spine problems prior to current symptoms? YES / NO (If yes please give brief history)

Have you had a fracture or broken bone over the age of 55 YES / NO

Do you take VitD and Calcium YES / NO

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Current Medications

Medication	Condition	Dose	Frequency

Medication Allergies Please list all allergies & reactions

Past Medical History (please list)

Family History (please list)

Social History

Family members at home and their health

Recreational Activities

Do you smoke YES / NO if yes how many per day?

Do you consume alcohol YES / NO If yes how many Std Drinks per week?

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