Southlake Orthopaedics
Sports Medicine and Spine Center

Dr. Kim's Patient Intake Questionnaire

Name: _____ Date: _____

How did your symptoms start: □ Suddenly □ Gradually □ Chronic/recurrent

Have you had spine surgery in the past? □ Yes □ No **If Yes, Type of Procedure:**_____

_____

What activities/positions make it worse:

□ Sitting	□ Sleep postures	□ Arm movements
□ Standing	□ Getting in/out of bed	□ Leg movements
□ Walking	□ Getting in/out of chair	□ First morning symptoms
□ Lying down	□ Driving	□ End of day symptoms
□ Bending	□ Computer work	□ Other: _____
□ Lifting	□ Stair climbing	
□ Coughing/sneezing	□ Neck movements	

What activities/positions/interventions make it better:

□ Lying down	□ Exercises	□ Heat
□ Sitting	□ Changing positions	□ Medications
□ Walking	□ Reclined positions	□ Better as the day progresses
□ Bending forward	□ Ice	□ Others: _____

Expectations: What expectations do you have for your treatment at this office?
(Select only ONE response for each statement)

As a result of my treatment, I expect…	**Not likely**	**Slightly Likely**	**Somewhat Likely**	**Very Likely**	**Extremely Likely**
Complete pain relief	□	□	□	□	□
Moderate pain relief	□	□	□	□	□
Do more everyday household or yard activities	□	□	□	□	□
To sleep more comfortably	□	□	□	□	□
To do my usual work/job	□	□	□	□	□
To do recreational activities (sports, walking, etc.)	□	□	□	□	□