NEW PATIENT BACK AND NECK QUESTIONNAIRE

PATIENT NAME: _____ **DATE OF VISIT:** _____

Please read and complete the attached questionnaire. As you answer each section, please be as specific as possible about your condition. Feel free to attach an additional page if you need more room to convey to us what you would like us to know. Your answers, in addition to your examination, will enable us to better reach an accurate diagnosis, assist us in designing a program to meet your specific needs as well as to be used where appropriate in your medical report. Please note that copies of your medical record will be sent to any referring physicians, insurance as appropriate, and to health care professionals who will be directly involved with any care resulting from this back or neck evaluation.

If this questionnaire was mailed to you, it must be returned at the time of your visit. This will save you the time of having to complete another one upon your arrival. Also, please remember to bring:

1. Any previous films, such as **x-rays, CAT scans, MRI scans,** etc.
2. **Any reports** you may have received regarding previous back surgeries.
3. **This completed questionnaire.**

This information will be entered into our clinical research data banks in order for us to determine the usefulness of various treatment techniques and provide documentation of your medical care.

Our staff here looks forward to seeing you and helping you with medical care.
Remember that we share a common goal ----- YOUR GOOD HEALTH AND WELL BEING.

Please provide the answers that describe your present abilities and condition.

1. PAIN ONSET

When did your pain begin? _____

Please describe briefly what injury it was that occurred to cause you such pain if an incident did occur.

2. WORK RELATED INJURY

Is this injury work related? ◯ Yes ◯ No If Yes, please answer the following questions:

1. What is the specific date on which your injury occurred? _____

2. What is the Claim number if this is a Labor and Industry case? _____

3. BODY MECHANICS

How many pounds are you able to **lift**? _____

How long are you able to **walk** without pain? _____Minutes; _____Hours

How long are you able to **sit** without pain? _____Minutes; _____Hours

How long are you able to **stand** without pain? _____ Minutes; _____ Hours

Are you having **trouble sleeping** at night? ◯ Yes ◯ No

4. PAIN RATIO

On a scale of 1 - 10, with **#1 = no pain** and **#10 = the most pain**, please rate your pain.

When my pain is at its **worst** it's a _____, my pain is **usually** a _____, at **best** it's a _____.

5. CONDITION

Has your condition gotten (circle one)... ◯ Worse ◯ Improved ◯ Unchanged

6. HELPFUL TREATMENTS OR RECOMMENDATIONS

Please circle treatments you have received that have been helpful in relieving your pain.

☐ Chiropractic	☐ Massage	☐ Hot Packs	☐ Traction
☐ Ultrasound	☐ Ice	☐ Physical Therapy	☐ TENS Unit
☐ Heat	☐ Back School	☐ Epidural/Facet Blocks	

Is your pain positional? Can you be in any position that alleviates your pain?

_____

Is there anything that aggravates your pain?

_____

7. BACK AND LEG PAIN ONLY: (Please circle one of the following)

The following percentages are to be filled out as they apply to your pain.

◯ 100% Back pain and 0% Leg pain

◯ 75% Back pain and 25% Leg pain

◯ 50% Back pain and 50% Leg pain

◯ 25% Back pain and 75% Leg pain

◯ 0% Back pain and 100% Leg pain

8. NECK AND ARM PAIN ONLY: (Please circle one of the following)

The following percentages are to be filled out as they apply to your pain.

- ◯ 100% Neck pain and 0% Arm pain
- ◯ 75% Neck pain and 25% Arm pain
- ◯ 50% Neck pain and 50% Arm pain
- ◯ 25% Neck pain and 75% Arm pain
- ◯ 0% Neck pain and 100% Arm pain

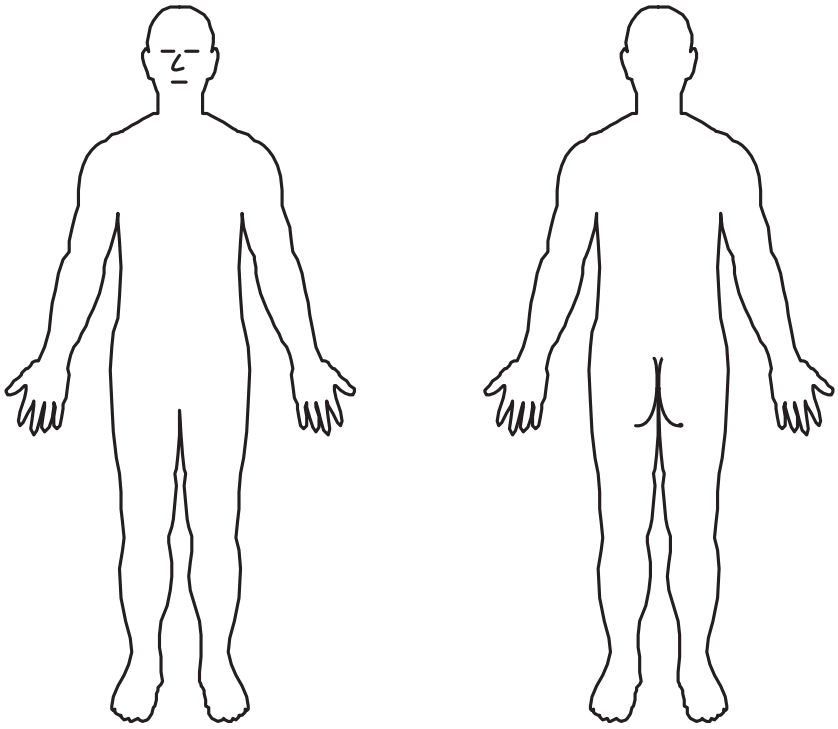
9. BODY DIAGRAM FOR PAIN INDICATION

Using the body diagram below please indicate the locations of any of the sensitivities listed. Mark the areas on the drawing with the symbol that best describes the sensation that you feel.

Complete this portion after printing.

SYMBOL	SENSATION
= = =	Numbness
x x x	Burning pain
o o o	Pins and Needles
/ / / /	Stabbing Pain
^ ^ ^	Aching Pain

Anatomical Position



10. DIAGNOSTIC TESTING / STUDIES PERFORMED

Please circle below what x-rays or studies you have already had done.

- ☐ None
- ☐ x-ray of spine or neck
- ☐ C.T. scan
- ☐ EMG
- ☐ Myelogram
- ☐ Discogram
- ☐ MRI scan
- ☐ Bone scan
- ☐ Other _____

11. PREVIOUS BACK PROBLEMS OR INJURIES

Have you had a **previous back problem** or injury? ◯ Yes ◯ No

If yes is your answer, please describe **when** and **how** this problem or injury occurred (lifting, bending, jumping, etc.) and **what kind of injury** you sustained. Please include where your pain was located (back, legs, arms, etc.)

Date of previous injury _____

12. SURGERIES PERFORMED

Have you had a previous Back surgery (ies)? ◯ Yes ◯ No

If yes is your answer, please indicate below;

How many _____ **When** they were performed _____

What surgery was performed _____

The name of the **surgeon** who performed them _____

Did you return to work after the injury? ◯ Yes ◯ No

If yes, did you return;

- ◯ Full time at the same job?
- ◯ Full time at a less strenuous job?
- ◯ Part time at the same job?
- ◯ Part time at a less strenuous job?

13. WORK STATUS

Please outline your current work status;

- ◯ I am working full time performing all of my regular work activities.
- ◯ I am working full time with modified work activities.
- ◯ I am working part-time at _____ hours a day.
- ◯ I have not been back to work since _____