Patient #_____

Back & Neck Questionnaire

Name:_____ Date:_____

DOB:_____ Age:_____ Sex:_____ Referring Doctor:_____

Accompanied by Name:_____ Relation:_____

----------REASON FOR VISIT----------

LEFT	
Yes	**REASON FOR VISIT**
	Neck Pain
	Arm Pain
	Arm Numbness
	Midback Pain
	Low Back Pain
	Buttocks Pain
	Leg Pain
	Leg Numbness

BILATERAL	
Yes	**REASON FOR VISIT**
	Neck Pain
	Arm Pain
	Arm Numbness
	Midback Pain
	Low Back Pain
	Buttocks Pain
	Leg Pain
	Leg Numbness

RIGHT	
Yes	**REASON FOR VISIT**
	Neck Pain
	Arm Pain
	Arm Numbness
	Midback Pain
	Low Back Pain
	Buttocks Pain
	Leg Pain
	Leg Numbness

Yes	DOMINANT HAND
	Right
	Left

Yes	DATE OF INJURY/SURGERY
	Date of injury
	Date of onset
	Date of surgery

SOCIAL		
Occupation:		
Yes		
	Full-time	
	Part-time	
	Retired	
	Restricted duty	
		Date of onset
	Disabled	
		Date of onset

----------SYMPTOMS----------

Yes	SYMPTOM STATUS
	Sudden onset
	Chronic
	Getting better
	Getting worse
	Staying the same
Yes	**TIMING OF PAIN**
	Constant (100% of the time)
	Frequent (75% of the time)
	Intermittent (50% of the time)
	Occasional (25% of the time)

Yes	PAIN INTENSITY (scale 0-10)
	Current Pain Level (0-10)
	Average Pain last 7 days (0-10)
	Worst Pain in last 7 days (0-10)

Yes	PAIN QUALITY
	Burning
	Throbbing
	Dull, aching
	Shooting
	Sharp
	Cramping

Yes	PAIN QUALITY
	Pressure like
	Electric like
	Cutting
	Numbness
	Tingling

----------SYMPTOMS CONTINUED ----------

Yes	SYMPTOMS
	Pain
	Numbness
	Tingling
	Weakness
	Headache
	Dizziness
	Changes in urinary habits
	Changes in bowel movements
	Abnormal walking

PAIN MODIFIERS			
Moderates Pain	**Relieves**	**Worsens**	**Unchanged**
Standing			
Walking			
Sitting			
Driving			
Lying down			
Nights			
Lifting			
Looking up			
Looking down			
Turn head side to side			
Coughing/Sneezing			
Exercise			
Bending			
Medication			
Twisting/Turning			
Housework/Yardwork			
Rising from a chair			

----------TREATMENTS & STUDIES ----------

Yes	PREVIOUS TREATMENT FOR BODY PART SEEN FOR TODAY
	Ice
	Heat
	Massage
	Exercise
	Bracing
	OTC Medications
	Steroid Medications
	Muscle Relaxants
	Pain Medication
	Physical Therapy
	Electrical Stimulation
	Ultrasound
	Chiropractic Care
	Acupuncture
	Traction
	Joint Injection
	Corticosteroid Injection
	Trigger Point Injection
	Epidural Injection
	Surgery

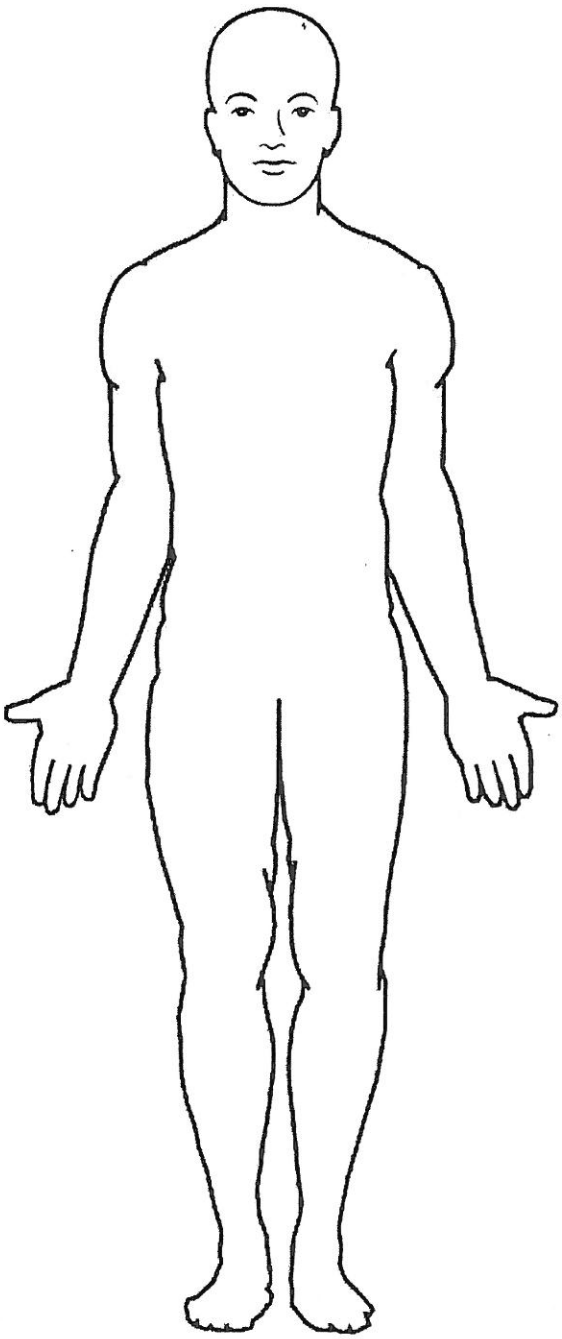
Yes	PREVIOUS TREATMENT FOR BODY PART SEEN FOR TODAY
	X-rays
	MRI Scan
	CT Scan
	Bone Scan
	EMG / Nerve Conduction Studies (NCS)
	CT Myelogram
	Discogram

Mark the areas on your body where you feel the described sensations.

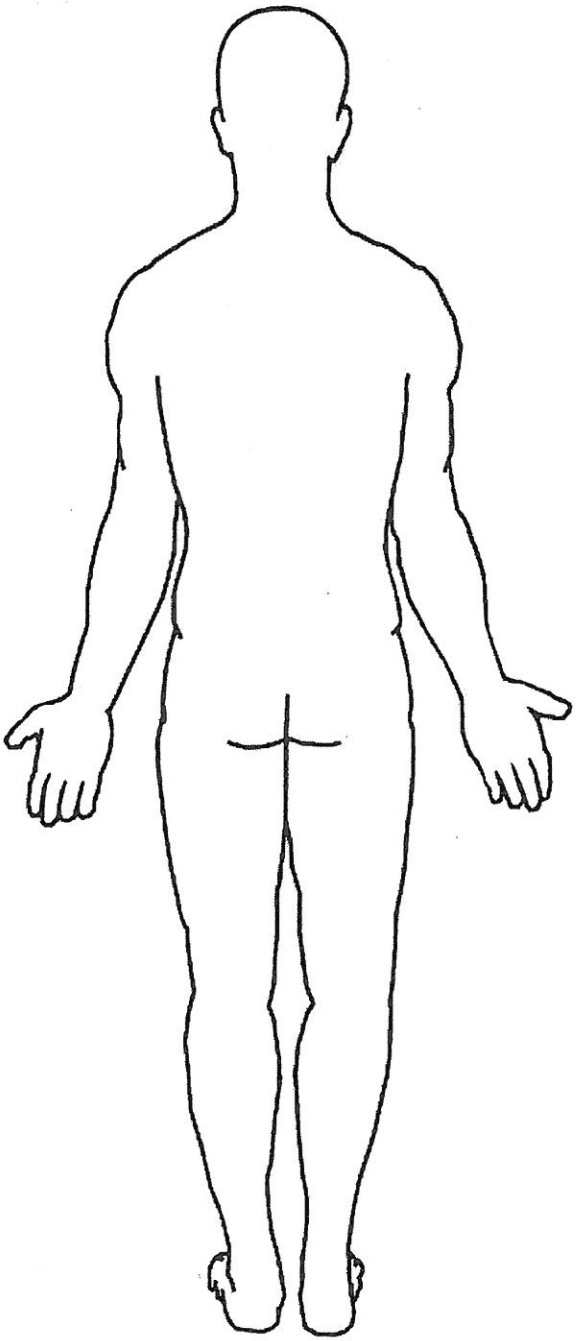
- Use the appropriate symbol.
- Mark areas of radiation and include all affected areas.

Numbness ---	**Burning** xxx	**Stabbing** ///	**Pins and Needles** 000
Cold CCC	**Tingling** >>>	**Sharp Pain** +++	**Dull Ache** \\\
Hot HHH			

Front



Back



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