All-Star Orthopaedics and Sports Medicine

Back & Neck Questionnaire

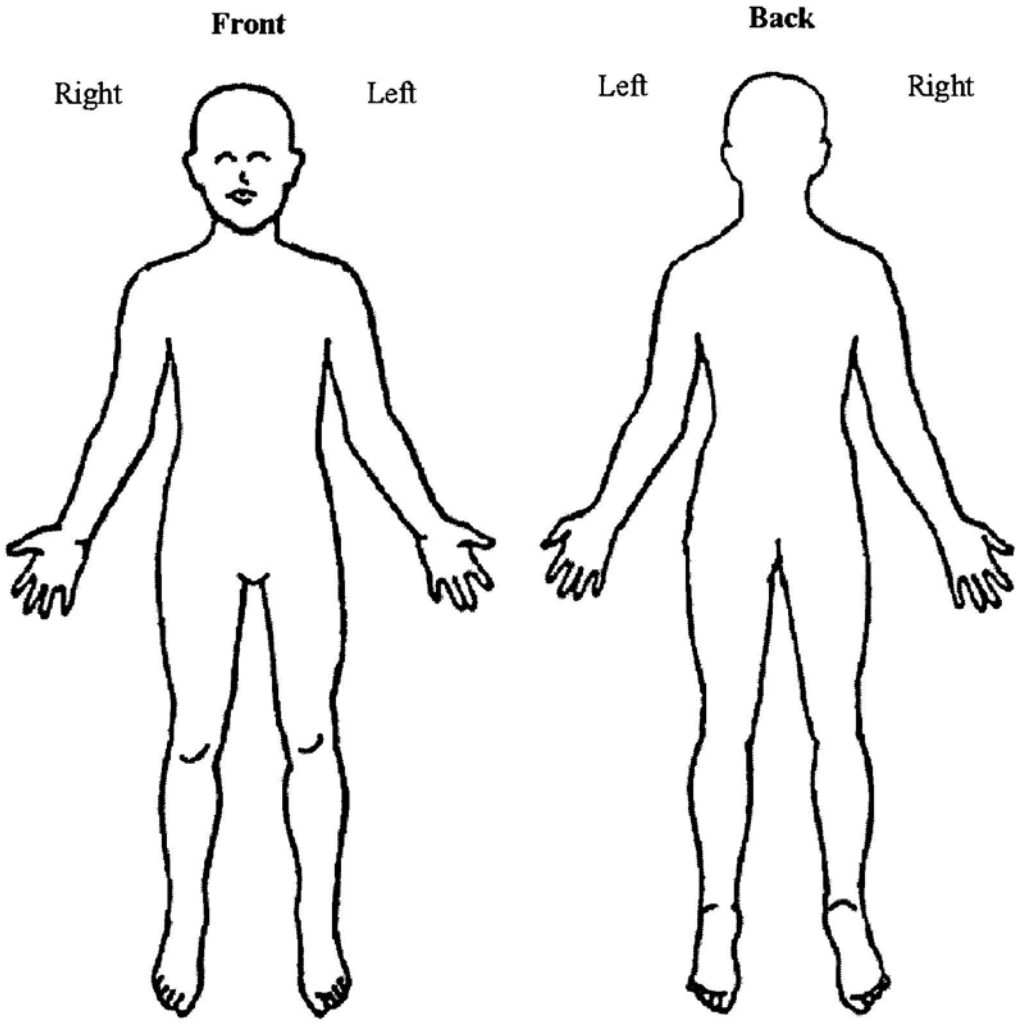
Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Primary Care Physician: _____ Referred by: _____

Date of Injury or Onset: _____ Occupation: _____

Mark in the areas of your body that you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below:

Pain	Numbness	Pins and Needles	Stabbing /////
XXXXX	OOOOO	=====	



Please mark on the line: How bad in your pain right now on a scale from 0-10?

0----------5----------10

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

A) Chief Complaint:

1) For the problem that caused you to visit us, please check with an [X]:
   - ☐ Neck Pain (Complete Section B)
   - [ ] Arm Pain or Numbness (Complete Section B)
   - ☐ Back Pain (Complete Section C)
   - ☐ Leg Pain of Numbness (Complete Section B)
   - ☐ Other:

2) How long have you had your main problem(s)? _____

3) Has this problem recently gotten worse? ☐ YES ☐ NO If YES, when?

_____

_____

4) What started the problem? _____

_____

_____

Continue to Section B if you have Neck Pain/ Arm Pain or Numbness
Continue to Section C if you have Back Pain/ Leg Pain or Numbness

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

B) Complete this section for Neck Pain/ Arm Pain or Numbness

If you are seeing the doctor for leg or back pain, skip this section and go to Section C

1) What portion of your pain is in your neck and how much is in your arm(s)?

Check only one:

- ☐ all NECK pain, no arm pain
- ☐ mostly NECK pain, only some arm pain
- ☐ neck pain and arm pain are about equal (50/50)
- ☐ only some neck pain, mostly ARM pain
- ☐ no neck pain, all ARM pain

2) There is:

- ☐ no arm pain
- ☐ RIGHT arm pain (no left arm pain)
- ☐ mostly RIGHT arm pain, some left arm pain
- ☐ right and left arm pain are about equal (50/50)
- ☐ mostly LEFT arm pain, some right arm pain
- ☐ LEFT arm pain (no right arm pain)

3) Do you have any numbness in the arms or hands? ☐ YES ☐ NO

If YES, where?

Left Side of Body	**Right Side of Body**
☐ arm	☐ arm
☐ forearm	☐ forearm
☐ thumb	☐ thumb
☐ index finger	☐ index finger
☐ long finger	☐ long finger
☐ ring finger	☐ ring finger
☐ small finger	☐ small finger

4) Do you have any weakness in the arms or hands? ☐ YES ☐ NO

If YES, where?

Left Side of Body	**Right Side of Body**
☐ shoulder	☐ shoulder
☐ arm	☐ arm
☐ forearm	☐ forearm
☐ hand/fingers	☐ hand/fingers

5) Please indicate which, if any, of these problems you are experiencing:

- ☐ difficulty picking up small objects or buttoning shirts
- ☐ problems with balance or frequent tripping
- ☐ headaches in the back of the head
- ☐ walking is difficult/impossible due to imbalance
- ☐ dropping objects because of weak or clumsy hands

Continue to Section D

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

C) Complete this section for Back Pain/ Leg Pain or Numbness

If you do not have lower back pain or leg problems, skip this section and go to Section D

1) What portion of your pain is in your back and how much is in your leg(s)?

Check only one:

- ☐ all BACK pain, no leg pain
- ☐ mostly BACK pain, only some leg pain
- ☐ back pain and leg pain are about equal (50/50)
- ☐ only some back pain, mostly LEG pain
- ☐ no back pain, all LEG pain

2) There is:

- ☐ no leg pain
- ☐ RIGHT leg pain (no left leg pain)
- ☐ mostly RIGHT leg pain, some left leg pain
- ☐ right and left leg pain are about equal (50/50)
- ☐ mostly LEFT leg pain, some right leg pain
- ☐ LEFT leg pain (no right leg pain)

3) The pain is mostly in what part(s) of your leg(s)?

Left Side of Body	**Right Side of Body**
☐ buttocks	☐ buttocks
☐ groin	☐ groin
☐ thigh back	☐ thigh back
☐ thigh front	☐ thigh front
☐ calf	☐ calf
☐ foot	☐ foot

4) How far can you walk before LEG PAIN makes you stop and rest?

- ☐ across the room
- ☐ 1 or 2 blocks
- ☐ across a parking lot
- ☐ 1 or 2 miles
- ☐ I can walk as far as I want without leg pain

5) Do you have any of the following?

- ☐ worse pain with sitting
- ☐ worse pain with standing/walking
- ☐ another medical problem (i.e. shortness of breath, chest pain, back pain) that limits walking
- ☐ weakness in legs

Continue to Section D

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

D) Treatment History - All patients should complete this section

1) Do you have a loss of bowel or bladder control? ☐ YES ☐ No
   If YES, what is the cause?

2) What treatments have you had and what was the effect?

	Better	Worse	No Change
☐ Physical Therapy	☐	☐	☐
☐ Injections	☐	☐	☐
☐ Pain Medication	☐	☐	☐
☐ Traction	☐	☐	☐

3) Have other doctors previously seen you regarding this problem? ☐ YES ☐ NO
   If YES, please provide contact information for any doctors seen previously.

Doctor Name	Specialty	City	Treatments

4) Have you had an MRI, CT, X-RAY, or EMG to evaluate your spine problems? [ ] YES [ ] NO
   If YES, please fill in the following table.

Test	Body Part	Date	Location