BACK & NECK QUESTIONNAIRE

Please answer all questions completely.

It is in your best interest and will assist your doctor with your care.
Be sure to bring this form with you to your appointment.

Patient Name: _____

Date: _____

DOB: _____

MRN: _____

AGE: _____

Height: _____**FT** _____**IN**

Weight: _____

1. **Referring doctors name and address:**

_____

_____

_____

2. **Internist/family doctor name and address:**

_____

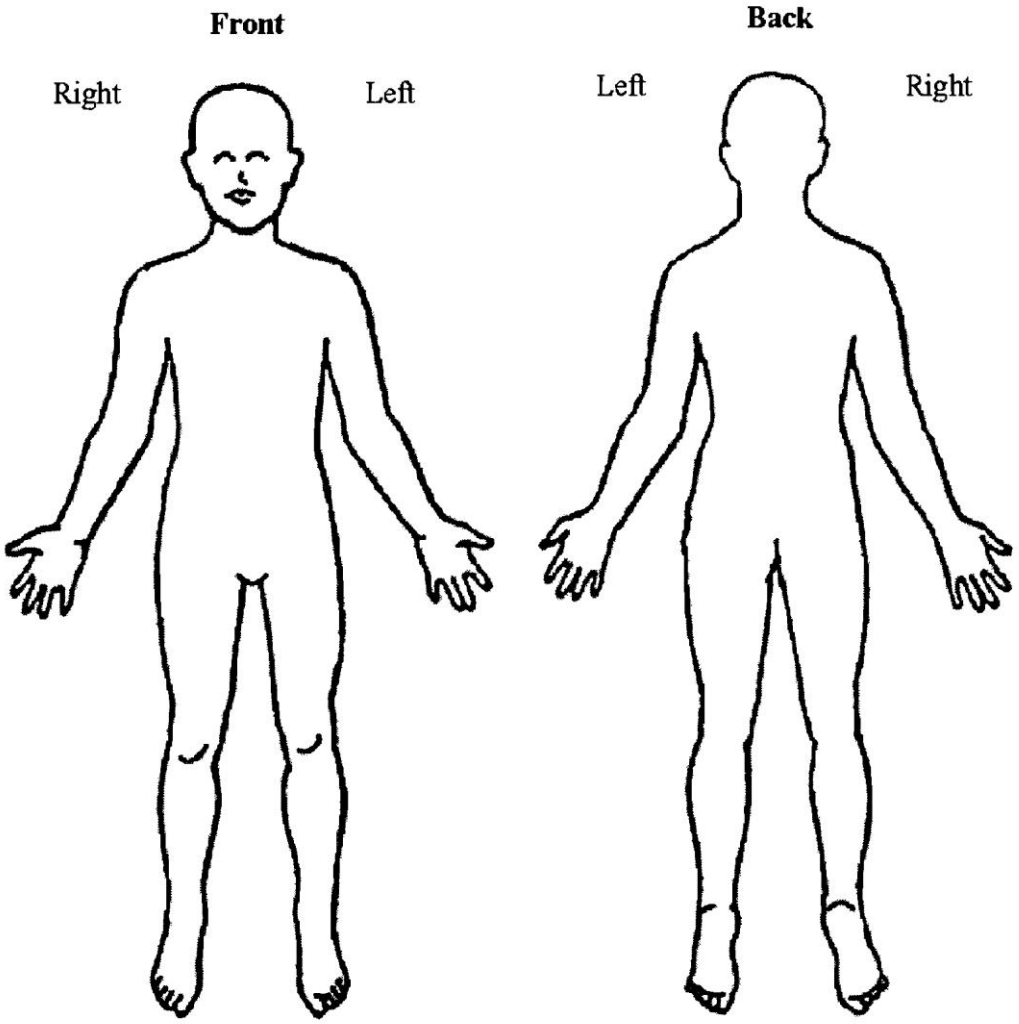
_____

_____

_____

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



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

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

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 or Numbness (Complete Section C)
   - [ ] Other: _____
2. How long have you had your main problem(s)? _____
3. Has this problem recently gotten worse? [ ] YES [ ] NO If so, 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

B. Complete this section for neck problems

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 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
   - [ ] 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 of 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.

C. Complete this section for back problems

If you do not have lower back or leg problems, skip this section. 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 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 of your leg(s)? Please check the areas with an [X].

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 (ie. Shortness of breath, chest pain, back pain) that limits walking
   [ ] Weakness in legs

CONTINUE TO SECTION D.

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**

E. Medical History – All patients should complete this section

In general, your health is (mark one): [ ] Excellent [ ] Good [ ] Fair [ ] Poor

[ ] Terrible. Have you ever had:

[ ] Asthma/Breathing problems	[ ] Phlebitis or blood clots
[ ] Diabetes (years_____)	[ ] Stroke
[ ] Cancer (Type_____)	[ ] Bleed or bruise easily
[ ] AIDS or HIV testing	[ ] Ulcer
[ ] Heart Attack	[ ] Rheumatoid arthritis
[ ] Hepatitis	[ ] High blood pressure

[ ] Fibromyalgia [ ] Reaction to anesthetics

[ ] Gall bladder disease [ ] High cholesterol

[ ] Kidney stones [ ] Tuberculosis

[ ] Seizures [ ] Migraines

[ ] Alcoholism [ ] Thyroid disease

[ ] Anemia [ ] Anemia

[ ] Pacemaker [ ] Other: _____

How much do you smoke? _____

How much do you drink? _____

Any other recreational drugs? [ ] YES [ ] NO if YES, what? _____

_____

1. Surgical History. Please provide the Surgery, Surgeon, and Date for any surgeries.

   Surgery **Surgeon** **Date**

   a) _____

   b) _____

2. Family History. Has anyone in your family have any of the following problems? Check all that apply.

   Explain

   Bleeding Problems [ ] YES [ ] NO _____

   Anesthesia Problems [ ] YES [ ] NO _____

   Heart Problems [ ] YES [ ] NO _____

   Spine Problems [ ] YES [ ] NO _____

F. Medications – All patients should complete this section

1. Are you allergic to any medications? [ ] YES [ ] NO If YES, please complete the following:

   Medication Name Rash Wheezing/Swelling Shock Upset Stomach other

   _____

   _____

   _____

3. Are you currently taking any medications (prescriptions or non-prescription)? [ ] YES [ ] NO If YES, complete the following:

A) _____

B) _____

C) _____

D) _____

G. Review of Systems: Check all that apply:

During the past year have you had?

[ ] Night Sweats	[ ] Unplanned weight loss
[ ] Loss of appetite	[ ] Excessive fatigue
[ ] Depression	[ ] Difficulty sleeping
[ ] Unusual stress in home life	[ ] Unexplained fevers
[ ] Unusual stress in work life	[ ] Easy bruising
[ ] Excessive bleeding	[ ] Lumps in neck, groin, armpits
[ ] Persistent unusual cough	[ ] Trouble breathing w/exercise
[ ] Trouble breathing lying flat	[ ] Coughing up blood
[ ] Swollen ankles	[ ] Persistent diarrhea
[ ] Excessive constipation	[ ] Dark black stools
[ ] Blood in stools	[ ] Pain or burning with urinating
[ ] Difficulty urinating (starting, stopping)	[ ] Blood in urine
[ ] Generalized morning stiffness	[ ] Dry eyes or mouth
[ ] Skin rash	[ ] Joint pain or swelling

Patient Signature: _____

Date: _____

Reviewed: _____