

Patient Questionnaire

Please complete the entire form before being seen

Date: _____

Dominant Hand: Right Left

Name: _____

Onset Symptoms: _____

Chief Complaint: _____

Duration of Symptoms: _____

Was your injury the result of one of the following (Circle all that apply):

1-Vehicle Accident

2-Recreational Accident

3-On the Job Injury

4-Unknown

Please briefly describe any associated events surrounding your symptoms:

On the pain diagram below mark the areas of your body where you feel your typical pain.

Circle the words which describe your pain:

Numbness

Pins/Needles

Burning

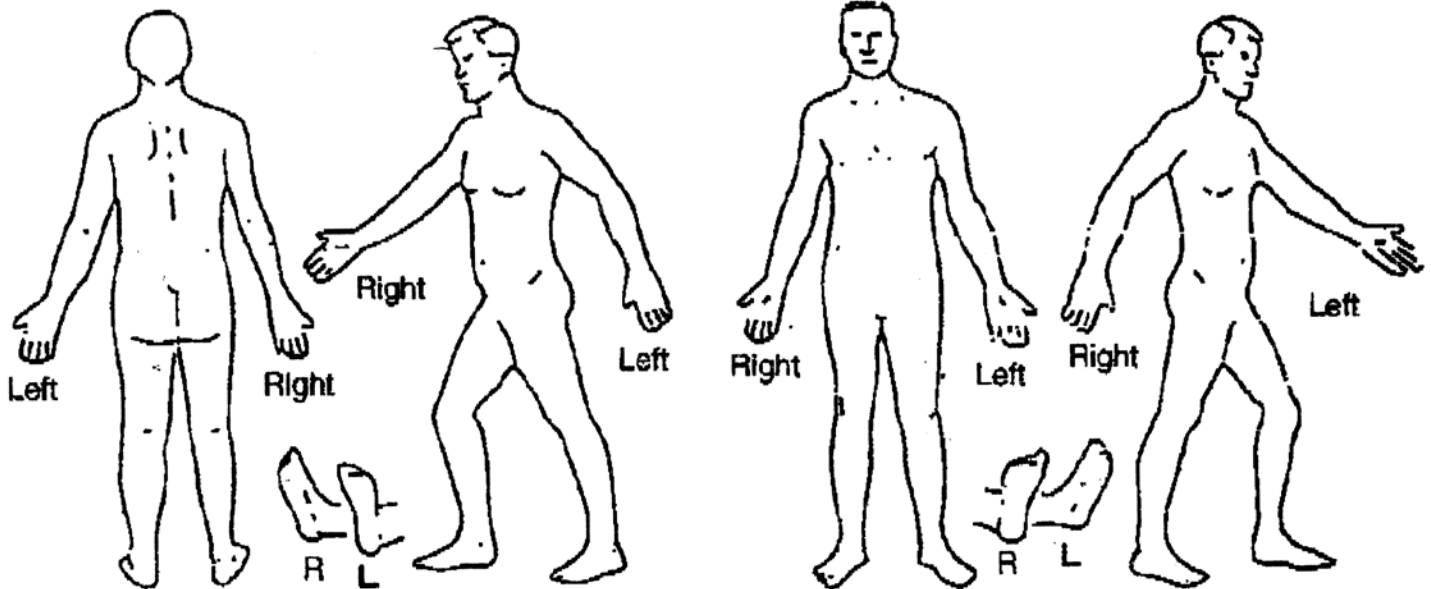
Achy

Tingling

Stabbing

Sharp

Dull



If you have neck problems, what percent of your pain is: (R) Arm: _____% (L) Arm: _____% Neck: _____%
(These 3 numbers should add up to 100%)

If you have back problems, what percent of your pain is: (R) Leg: _____% (L) Leg: _____% Back: _____%
(These 3 numbers should add up to 100%)

Circle the activities which **most increase your pain & make you feel worse:**

Sitting

Standing

Walking

Bending forward

Bending backward

Coughing

Sneezing

Bowel movement

Circle the activities which **most decrease your pain & make you feel better:**

Leaning Forward Lying Down Sitting Standing Heat Cold Meds

Rate your pain level: range **0 - no pain** and **10 = severe pain**

Right Now: (Circle one)

0 1 2 3 4 5 6 7 8 9 10

Symptoms at their best: (Circle one)

0 1 2 3 4 5 6 7 8 9 10

Symptoms at their worst: (Circle one)

0 1 2 3 4 5 6 7 8 9 10

Do you have any weakness in your legs or arms? _____ If so, for how long? _____

Do you have problems with your balance, fine motor skills, bowel or bladder function? (circle)

Mark with an "X" the worst and best times of day for your pain:

WORST

BEST

____ First awakening

____ First awakening

____ Morning

____ Morning

____ Afternoon

____ Afternoon

____ Evening

____ Evening

Does your neck/back pain affect your sleep? Yes or No

Which of the following diagnostic test(s) were done for your symptoms?

X-Rays CT Scan MRI Scan EMG Bone Scan

Check the treatments you have used and what best describes their effect.

Treatment

Helped

Worsened

Unaffected

Anti-Inflammatory Medication

Pain Medication

Muscle Relaxant Medication

Physical Therapy

Chiropractic Treatment

Acupuncture

Local (trigger point) Injections

Facet Joint Injections

Epidural Steroid Injections

Anti-Depressant Medication

Other:

Are you currently getting any treatments listed above? Yes or No

What are some of your usual recreational activities? Mark with an "X" next to those you no longer participate in because of your back or neck symptoms.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____