Neurological Surgery and Spine Surgery, S.C.
1 Westbrook Corporate Center, Suite 800
Westchester, Illinois 60154

BACK AND NECK PAIN QUESTIONNAIRE

Please **PRINT** all information **CLEARLY** and answer all questions completely
*Note that there are questions on **BOTH SIDES** of each page*

Date: _____

Name: _____

Please provide exact information below if you were referred by:

( ) Doctor _____

( ) Employer _____

( ) Insurance Provider _____

( ) Lawyer _____

Address _____

Phone _____

Please provide the following information regarding your primary care physician:

Primary Care Physician Name _____

Address _____

Phone _____

Fax _____

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Please circle if you are: Left-handed Right-handed

Male Female Age_____

• Briefly state what complaint brings you to the office today and when your pain began

• Do you have numbness, tingling or burning in the arms or legs? **YES** **NO**

• Do you have any weakness in the arms or legs? **YES** **NO**

• Are your symptoms: ____ Constant or ____ Periodic?

• Using a pain scale from 1-10 (**1** being **slight**; **10** being **severe**), describe your pain?

1 2 3 4 5 6 7 8 9 10

• What makes your symptoms **worse**? (i.e positions, activities, etc.)

• What makes your symptoms **better**? (i.e positions, activities, medications, heat/ice etc)

• Are your symptoms affecting your daily life? **YES** **NO**
- If YES, please describe:

• Have you had any previous episodes of back/ leg/ neck/ arm pain? **YES** **NO**
- If YES, please describe:

PAST MEDICAL HISTORY

• Do you have any types of **medical problems**? **YES NO**

- If YES, please describe (i.e. high blood pressure, high cholesterol, diabetes, heart, lung, kidney, thyroid, anxiety, depression, glaucoma, bleeding disorders, etc.)

• Have you had ANY **surgery**? **YES NO**

- If YES, list ALL the type(s) of surgery and date(s):

• Do you take ANY **medications** for any problems? **YES NO**

- If YES, please list the names and doses of medications you take and how frequently. Please list any vitamins or dietary supplements as well:

• Are you **allergic** to any medications? **YES NO**
- If YES, please list:

• What **Treatments** have you tried for this problem and what type of response did you have?

	No Relief	**Some Relief**	**Good Relief**
Rest			
Medication (NSAIDS, Tylenol, Oral Steroids)			
Physical Therapy			
Spinal or muscle injection			
Chiropractic Treatment			
Neck Collar, Lumbar Corset or Brace			

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SOCIAL HISTORY

• For what company do you work? _____

• What is your position or job title? _____

• Is your work mostly:

Heavy physical	(lifting 50 - 100 lbs.)	_____
Medium physical	(lifting 25 - 50 lbs.)	_____
Light physical	(lifting up to 20 lbs.)	_____
Desk work		_____
Driving		_____

• Are you working now? **YES** **NO**

• What year did you begin working at this job? _____

• If you are **NOT** working now, when was the **LAST DAY** you worked?____/____/_____

• What is the main reason you are off work? _____

• Please describe your SITTING TOLERANCE:
_____ **None**
_____ **Less than one (1) hour**
_____ **Less than three (3) hours**
_____ **More than three (3) hours**

• Please describe your STANDING TOLERANCE:
_____ **Less than one (1) hour**
_____ **More than one (1) hour**

• Please describe your WALKING TOLERANCE:
_____ **Less than two (2) blocks**
_____ **More than two (2) blocks**

• Do you **smoke**? **YES** _____ **packs/day** **NEVER** _____ **QUIT** _____
- If you are a smoker or if you quit, for how many years have you smoked? _____ **yrs**

• Do you drink **alcohol**? **YES** **NO**
- If YES, <u>what</u> do you drink, and <u>how much</u> do you drink? _____

• Do you **exercise**? **YES** **NO**
- If YES, <u>how many times a week</u> and <u>what type</u> of exercise do you do? _____

• For all patients, when was your last Colonoscopy? _____
• If female patient, when was your last Mammogram? _____
• If female patient, when was your last Pap Smear? _____

REVIEW OF SYSTEMS

• Have you had any recent fever, cold, chills, night sweats or infection? **YES NO**

- If YES, please describe: _____

• Have you had unintentional lost weight in the past 6 months? **YES ___lbs NO**

• Do you experience frequent headaches? **YES NO**

- If YES, how often?_____

• Do you get nausea or have vomiting? **YES NO**

• Do you have recent vision changes, blurry vision or double vision? **YES NO**

• Do you experience dizziness? **YES NO**

• Do you experience seizures? **YES NO**

• Do you get ringing in the ears? **YES NO**

• Do you experience chest pain or palpitations? **YES NO**

• Do you experience shortness of breath or breathing problems? **YES NO**

• Have you had abdominal pain? **YES NO**

• Do you have any bowel or bladder problems? **YES NO**

- If YES, please describe: _____

• Do you have experience difficulty with sexual function? **YES NO**

• Please tell us about any other medical problems or concerns:

(THIS PAGE WILL BE FILLED OUT BY YOUR PROVIDER)

NEW PATIENT EXAMINATION

HEIGHT: _____ INCHES **WEIGHT: _____LBS**

V/S: B/P _____/_____ **HR: _____**

NEURO: **WALK:**

MOTOR: **HEEL/TOE:**

SENSORY: **PP -**
VI -
LT -

SQUAT:

REFLEXES: **ROM: ____/____/____/____**

PULSES: **RHOMBERG:**

SPUR / HOFF / BAB / SLR

OTHER/WOUND/ETC:

TESTING RESULTS (MRI / XRAY / CT / EMG) FROM _____

A/P: