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

BACK AND NECK PAIN QUESTIONNAIRE

Please PRINT all information CLEARLY. 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

Referred by _____

Address _____

Phone _____

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BACK AND NECK PAIN QUESTIONNAIRE

Please circle if you are: left handed right-handed Age_____
M____ F____

• How and when did your pain begin?

_____

_____

_____

_____

_____

_____

• Are your symptoms: ____ **Constant** **or** ____ **Periodic?**

• Do you have numbness, tingling or burning in the leg/foot or arm/hand? **YES** **NO**

• Have you experienced any weakness in the leg/foot or arm/hand? **YES** **NO**

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

• What seems to make your symptoms **better**? (i.e. positions, activities, medication heat, ice, etc.)

• Are you able to drive a car? **YES** **NO**

• Are you able to put on your shoes and socks? **YES** **NO**

• Have you had any previous episodes of back/ leg/ neck/ arm pain? **YES** **NO**

- If YES, please describe:

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

- If YES, please describe (i.e. high cholesterol, diabetes, high blood pressure, heart, lung, kidney, thyroid problems etc.)

• Have you had <u>any</u> **surgery**? **YES NO**

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

• Do you take <u>any</u> **medications** for any problems? **YES NO**

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

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

• What **TREATMENT** have you had for your neck/back problems? What type of response did you have to the treatment?

	No Relief	**Some Relief**	**Good Relief**
Bed Rest			
Physical Therapy			
Spinal or muscle injection			
Chiropractic Treatment			
Soft Collar			
Lumbar Corset or Brace			

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• 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 _____

• How long have you worked at that job? _____

• Are you working now? **YES** **NO**

If you have **NOT** been working at that job, when was the **LAST DAY** you worked?

_____/_____/_____

• What is the main reason you are off work?

• Do you **smoke**? **YES** _____**packs/day** **NO**

- If YES, for how long have you smoked? _____ **years**

• 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**

• On a pain scale from 1-10 (**1** being **slight** pain; **10** being **severe** pain), what number would you use to describe your pain?

1 2 3 4 5 6 7 8 9 10

• Do you have a family history of a **female** family member having a **heart attack** before the age of **65**? **YES NO**

• Do you have a family history of a **male** family member having a **heart attack** before the age of **55**? **YES NO**

• Do you drink **alcohol**? **YES NO**

- If YES, what do you drink, and how much do you drink?

_____

• Do you **exercise**? If you do, what kind of exercises do you participate in and how many times per week do you do those activities?

_____

• When was your last **colonoscopy**? _____ (date, if known)

• For **women** : When was your last **mammogram**? _____ (date, if known)

• Have you had any recent fever, colds or infections: **YES NO**

- If YES, please describe: _____

• Have you lost weight over the past 6 months? **YES** ___**lbs NO**

• Have you ever had any kind of tumor? **YES NO**

- If YES, please describe: _____

• Do you have problems with blurry vision or poor vision? **YES NO**

• Do you experience difficulty sleeping? **YES NO**

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- Do you get ringing in the ears? **YES NO**
- Have you ever had chest pain or palpitations? **YES NO**
- Have you ever had shortness of breath or breathing problems? **YES NO**
- Do you get nausea or have vomiting? **YES NO**
- Do you have headaches? **YES NO**
  - If YES, how often?_____
- Have you had abdominal pain or changes in your bowel habits? **YES NO**
- Do you have any bowel or bladder problems? **YES NO**
  - If YES, please describe: _____
- Do you have any difficulty with sexual function? **YES NO**
- Please tell us about any other medical problems or concerns: