

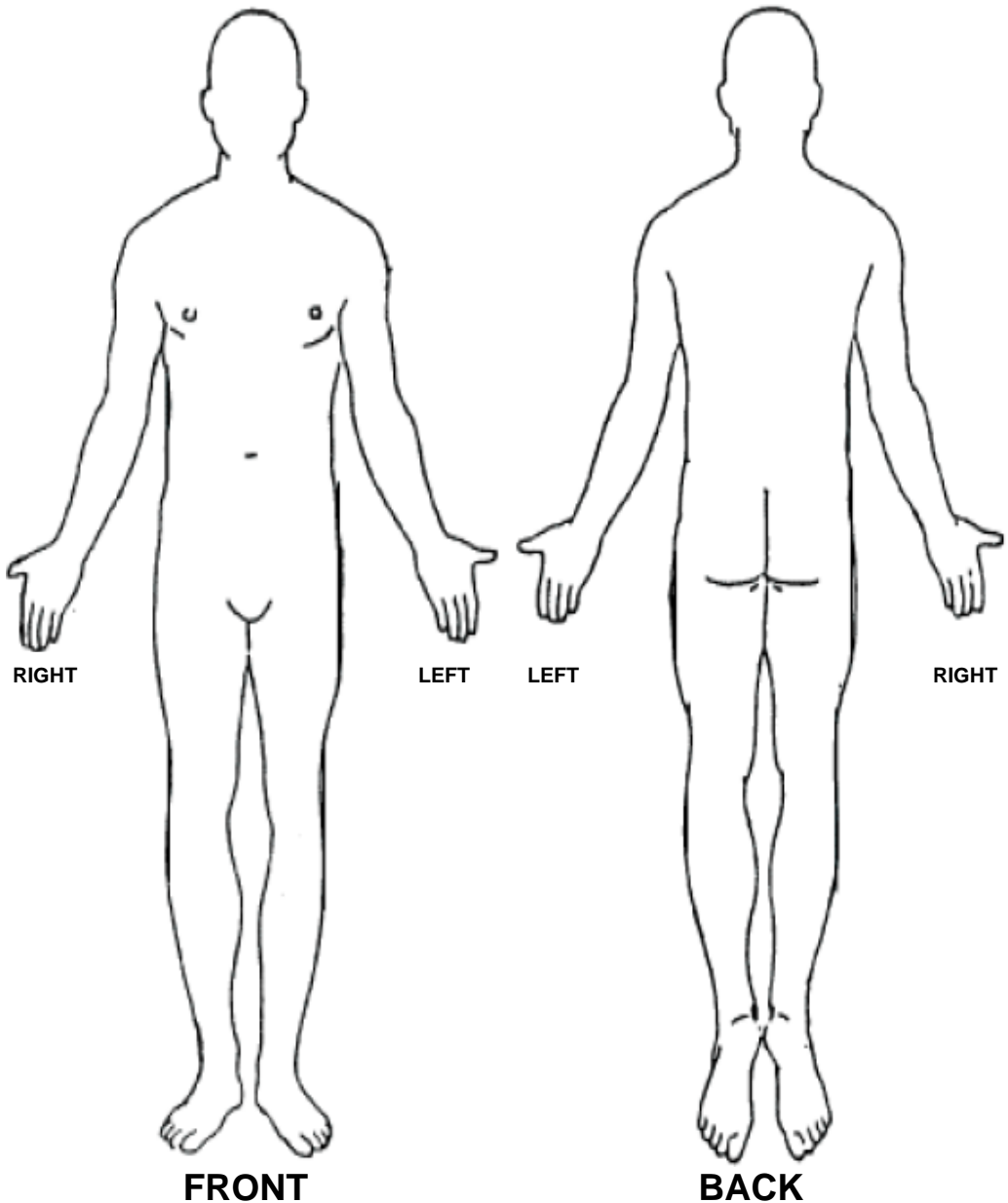
**Please fill out these forms completely!**  
 We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.  
 Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.  
**Thank you for helping us to know you better!**

Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
(please print)  
 Gender:    Male    Female  
 Date of Birth: \_\_\_\_\_  
(month/day/year)  
 Current Age: \_\_\_\_\_

**PAIN DIAGRAM**

**Please mark the areas where you feel the following sensations. Pay attention to right and left sides.**

- Ache**  
 ^ ^ ^ ^ ^  
 ^ ^ ^ ^ ^  
 ^ ^ ^ ^ ^
- Numbness**  
 O O O O  
 O O O O  
 O O O O
- Pins & Needles**  
 = = = =  
 = = = =  
 = = = =
- Burning**  
 X X X X  
 X X X X  
 X X X X
- Stabbing**  
 / / / /  
 / / / /  
 / / / /



**FACTORS OF COMPLAINT**

**What do you want to happen as a result of this visit?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)**

I don't know how it began.

It comes and goes.

I've had it a long time. (\_\_\_\_years)

Injury (date of injury\_\_\_\_) On the job?    yes    no

Please explain how the injury happened.

\_\_\_\_\_

Are you currently in litigation with regards to your back pain?  
yes    no

Have you been laid off from your job?    yes    no    N/A

**How bad is your pain? Place an "X" (—X—) on each of the lines below to indicate your pain.**

How bad is your **low back** pain?

\_\_\_\_\_

How bad is your **leg** pain?

\_\_\_\_\_

How bad is your **middle back** pain?

\_\_\_\_\_

How bad is your **neck** pain?

\_\_\_\_\_

How bad is your **arm** pain?

\_\_\_\_\_

**Do you have any of the following problems?**  
(Please check your answer.)

Is your pain worse at night?            yes    no

Does your pain awaken you from sleep?    yes    no

Does coughing affect your pain?            yes    no

Do your legs tire/hurt if you walk too far?    yes    no

    If YES, how far can you walk?

        less than 1 block      1-3 blocks      more than 3 blocks

Is this relieved by resting your legs?    yes    no

Is this relieved by bending forward?    yes    no

**Bladder Control (urine):**

No problem

Can't empty bladder

Loss of urine (accidents)

**Bowel Control:**

No problem

Constipation

Loss of control (accidents)

**How does each of the following affect you pain? (check your answer)**

Sitting	Better	Worse	No change	
Standing	Better	Worse	No change	
Walking	Better	Worse	No change	
Lying down	Better	Worse	No change	
Rising from chair	Better	Worse	No change	
Physical activity	Better	Worse	No change	
Heat	Better	Worse	No change	Don't know
Cold	Better	Worse	No change	Don't know
Massage	Better	Worse	No change	Don't know

**PREVIOUS TREATMENT**

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

**Have you had:**

Chiropractic care	better	worse
Physical therapy	better	worse
Injections	better	worse
Psychological consultation	better	worse
Other: _____	better	worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

<6 mo   < 12 mo

X-rays  
 MRI scan  
 CT scan  
 Myelogram  
 Discogram  
 EMG/NCV(nerve test)

Have you ever had surgery on your back or neck?

yes   no   If YES, complete the following:

1) Type of surgery \_\_\_\_\_  
 Date \_\_\_\_\_  
 Surgeon \_\_\_\_\_  
 Did it make your pain        better or    worse?

2) Type of surgery \_\_\_\_\_  
 Date \_\_\_\_\_  
 Surgeon \_\_\_\_\_  
 Did it make your pain        better or    worse?

3) Type of surgery \_\_\_\_\_  
 Date \_\_\_\_\_  
 Surgeon \_\_\_\_\_  
 Did it make your pain        better or    worse?

**GENERAL MEDICAL HISTORY**

Check all the conditions below that you have currently or have had in the past. If NONE check

Heart attack	Colon problems	Gout	Enlarged prostate
Heart murmur	Diabetes	Anxiety	Menstrual problems
Angina	Hepatitis	Depression	Cancer: type _____
High blood pressure	Cirrhosis	Emphysema	Osteoporosis
Stroke	Kidney stones	Tuberculosis	Have you used :
Varicose veins	Kidney infection	Chronic bronchitis	Immuno-suppression?
Stomach ulcer	Degenerative arthritis	Frequent pneumonia	Corticosteroids
Duodenal problems	Rheumatoid arthritis	Asthma	Other _____
Anemia (low blood count)	Bleeding tendency	Sexual difficulty	

List any major surgery you have had, other than on your back or neck.

Type of surgery	Year
1. _____	_____
2. _____	_____
3. _____	_____

Are you allergic to any medications?

yes   no   If YES, list the medications.

\_\_\_\_\_  
 \_\_\_\_\_

Do you take any medications, including herbal, over-the-counter, and prescription?

yes   no   If YES, list all medications you are taking.

Medication	Reason taken	How often taken	Doctor (if prescribed)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY MEDICAL HISTORY**

<b>I do not know the medical history of my biological parents or other family members.</b> (Go on to next section.)	<b>Mother:</b> Alive age: _____ Deceased at age: _____ due to _____	<b>Father:</b> Alive age: _____ Deceased at age: _____ due to _____	Number of living brothers/sisters _____, Number of deceased brothers/sisters _____, cause(s) _____
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**Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:**

Check all that apply:

Heart trouble	Kyphosis
Stroke	Arthritis
Diabetes	None of these
Lung disease	Don't know
High blood pressure	Other _____
Cancer	
Osteoporosis	
Scoliosis	

**SOCIAL HISTORY**

<b>Marital Status</b> Married Separated Divorced Single Widow/widower	<b>Smoking</b> Do you now, or have you ever smoked? yes no  If YES, please complete the following: I smoke _____ packs per day and I have smoked for _____ years.  <i>or</i> I did smoke _____ packs per day for _____ years, but I quit smoking _____ years ago.  Do you use any smokeless tobacco product? yes no	<b>Alcohol</b> Do you drink: Beer? yes no Wine? yes no "Hard" drinks? yes no  Frequency of drinking: never rarely socially (how often _____) daily  Do you have a history of heavy drinking? yes no
<b>Education</b> Check the highest level completed: Grammar school High school College Post-graduate		

<b>Effect of your back/neck pain on your lifestyle.</b>  I describe my home setting as supportive of me during this time. yes no I describe my work setting as supportive of me during this time. yes no My pain has affected my interaction with my family and friends. yes no The changes in my lifestyle due to my problem have been difficult for me. yes no	<b>What is your ability to enjoy life?</b> Excellent Very good Good Fair Poor
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<b>Please indicate your <u>current work status</u>.</b> Working full time Working part time Seeking employment Not working by choice (retired, homemaker, student, etc.) Physically unable to work <u>due to</u> back/neck problem Physically unable to work <u>not due to</u> back/neck problem	<b>Before having back or neck pain, did you normally work:</b> full time part time neither <b>What is your usual occupation?</b> _____ <b>Do you like your work situation?</b> yes no N/A
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**Has your pain affected your ability to do your job or any other daily activities?** yes no  
 If YES, please explain \_\_\_\_\_

**Is there anything we have failed to ask that you believe is important for us to know?**  
 yes no If YES, please explain: \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Do you have any allergies other than to medications (such as to latex, shellfish, etc.)?**

yes no If YES, describe. \_\_\_\_\_

**Do you have any of the following?**

**General:**

Recent weight loss of more than 10 pounds?    yes    no  
 Recent weight gain of more than 10 pounds?    yes    no  
 Fever?    yes    no  
 Chills?    yes    no  
 Night sweats?    yes    no

Have you seen your primary care physician in the past year?    yes    no

**Cardiac:**

Chest pain    yes    no  
 Shortness of Breath    yes    no

**Respiratory:**

Wheezing    yes    no  
 Pneumonia    yes    no  
 Chronic cough    yes    no

**Gastrointestinal:**

Abdominal pain    yes    no  
 Nausea    yes    no  
 Vomiting    yes    no  
 Diarrhea    yes    no  
 Liver problems    yes    no

**Skin:**

Open sores    yes    no  
 New moles    yes    no  
 Poor healing    yes    no  
 Skin infection    yes    no

**Hematologic/Oncologic:**

Easy bruising    yes    no  
 Blood thinning medications    yes    no  
 Blood transfusion    yes    no  
 Organ transplant    yes    no

**Bones/Joints:**

Shoulder pain    yes    no  
 Wrist/hand pain    yes    no  
 Hip pain    yes    no  
 Knee pain    yes    no  
 Lupus    yes    no  
 Muscle weakness    yes    no  
 Fibromyalgia    yes    no

**Genitourinary:**

Abnormal kidney function    yes    no  
 Pain with urination    yes    no  
 Frequent urinary infections    yes    no

**Nervous System:**

Headaches    yes    no  
 Tremors    yes    no  
 Poor speech    yes    no  
 Changes in vision    yes    no

**Mental Health:**

Sleep disturbances    yes    no  
 Feeling of hopelessness    yes    no

**Endocrine:**

Thyroid problems    yes    no

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## BACK PAIN QUESTIONNAIRE

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**If you have LOW BACK pain- complete this page,**  
**if you only have neck pain, skip this page.**

**Please Read:** This questionnaire is designed to give us information on how your back(or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark the one box in each section that most closely describes you today.

### Section 1 – Pain Intensity

I have no pain at the moment.  
 The pain is very mild at the moment.  
 The pain is moderate at the moment.  
 The pain is fairly severe at the moment.  
 The pain is very severe at the moment.  
 The pain is the worst imaginable at the moment.

### Section 6 – Standing

I can stand as long as I want without extra pain.  
 I can stand as long as I want but it gives me extra pain.  
 Pain prevents me from standing for more than 1 hour.  
 Pain prevents me from standing more than 1/2 an hour.  
 Pain prevents me from standing for more than 10 mins.  
 Pain prevents me from standing at all.

### Section 2 – Personal Care (washing, dressing, etc.)

I can look after myself normally without causing extra pain.  
 I can look after myself normally but it is very painful.  
 It is painful to look after myself and I am slow and careful.  
 I need some help but manage most of my personal care.  
 I need help everyday in most aspects of self care.  
 I do not get dressed, wash with difficulty, an stay in bed.

### Section 7 – Sleeping

My sleep is never disturbed by pain.  
 My sleep is occasionally disturbed by pain.  
 Because of pain I get less than 6 hours sleep.  
 Because of pain I get less than 4 hours sleep.  
 Because of pain I get less than 2 hours sleep.  
 Pain prevents me from sleeping at all.

### Section 3 – Lifting

I can lift heavy weights without extra pain.  
 I can lift heavy weights, but it gives extra pain.  
 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.  
 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.  
 I can lift very light weights.  
 I cannot lift or carry anything at all.

### Section 8 – Sex Life (if applicable)

My sex life is normal and causes no extra pain.  
 My sex life is normal but causes some extra pain.  
 My sex life is nearly normal but is very painful.  
 My sex life is severely restricted by pain.  
 My sex life is nearly absent because of pain.  
 Pain prevents any sex life at all.

### Section 4 – Walking

Pain does not prevent me from walking any distance.  
 Pain prevents me walking more than 1 mile.  
 Pain prevents me walking more than 1/2 mile.  
 Pain prevents me walking more than 100 yards.  
 I can only walk using a stick or crutches.  
 I am in bed most of the time and have to crawl to the toilet.

### Section 9 – Social Life

My social life is normal and causes me no extra pain.  
 My social life is normal but increases the degree of pain.  
 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.  
 Pain has restricted my social life and I do not go out as often.  
 Pain has restricted my social life to my home.  
 I have no social life because of pain.

### Section 5 – Sitting

I can sit still in any chair as long as I like.  
 I can sit in my favorite chair as long as I like.  
 Pain prevents me sitting more than 1 hour.  
 Pain prevents me sitting more than 1/2 hour.  
 Pain prevents me sitting more than 10 mins.  
 Pain prevents me from sitting at all.

### Section 10 – Traveling

I can travel anywhere without extra pain.  
 I can travel anywhere but it gives me extra pain.  
 Pain is bad but I can manage journeys over two hours.  
 Pain restricts me to journeys of less than one hour.  
 Pain restricts me to short necessary journeys under 30 minutes.  
 Pain prevents me from traveling except to receive treatment.

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## NECK PAIN QUESTIONNAIRE

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### If you have NECK pain- complete this page.

**Please Read:** This questionnaire has been designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please just mark the one choice which most closely describes your problem right now.

#### **Section 1 – Pain Intensity**

I have no pain at the moment.  
 The pain is very mild at the moment.  
 The pain is moderate at the moment.  
 The pain is fairly severe at the moment.  
 The pain is very severe at the moment.  
 The pain is the worst imaginable at the moment.

#### **Section 2 – Personal Care (washing, dressing, etc.)**

I can look after myself normally without causing extra pain.  
 I can look after myself normally, but it causes extra pain.  
 It is painful to look after myself and I am slow and careful.  
 I need some help, but manage most of my personal care.  
 I need help everyday in most aspects of self care.  
 I do not get dressed, wash with difficulty and stay in bed.

#### **Section 3 – Lifting**

I can lift heavy weights without extra pain.  
 I can lift heavy weights, but it gives extra pain.  
 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.  
 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.  
 I can lift very light weights.  
 I cannot lift or carry anything at all.

#### **Section 4 – Reading**

I can read as much as I want to with no pain in my neck.  
 I can read as much as I want to with slight pain in my neck.  
 I can read as much as I want with moderate pain in my neck.  
 I cannot read as much as I want because of moderate pain in my neck.  
 I cannot read as much as I want because of severe pain in my neck.  
 I cannot read at all.

#### **Section 5 – Headaches**

I have no headache at all.  
 I have slight headaches which come infrequently.  
 I have moderate headaches which come infrequently.  
 I have moderate headaches which come frequently.  
 I have severe headaches which come frequently.  
 I have headaches almost all the time.

#### **Section 6 – Concentration**

I can concentrate fully when I want to with no difficulty.  
 I can concentrate fully when I want to with slight difficulty.  
 I have a fair degree of difficulty in concentrating when I want to.  
 I have a lot of difficulty in concentrating when I want to.  
 I have a great deal of difficulty in concentrating when I want to.  
 I cannot concentrate at all.

#### **Section 7 – Work**

I can do as much work as I want to.  
 I can only do my usual work, but no more.  
 I can do most of my usual work, but no more.  
 I cannot do my usual work.  
 I can hardly do any work at all.  
 I cannot do any work at all.

#### **Section 8 – Driving**

I can drive my car without any neck pain.  
 I can drive my car as long as I want with slight pain in my neck.  
 I can drive my car as long as I want with moderate pain in my neck.  
 I cannot drive my car as long as I want because of moderate pain in my neck.  
 I can hardly drive at all because of severe pain in my neck.  
 I cannot drive my car at all.

#### **Section 9 – Sleeping**

I have no trouble sleeping.  
 My sleep is slightly disturbed (less than 1 hour sleepless).  
 My sleep is mildly disturbed (1 -2 hours sleepless).  
 My sleep is moderately disturbed (2-3 hours sleepless).  
 My sleep is greatly disturbed (3-5 hours sleepless).  
 My sleep is completely disturbed (5-7 hours sleepless).

#### **Section 10 – Recreation**

I am able to engage in all of my recreational activities with no neck pain at all.  
 I am able to engage in all of my recreational activities with some pain in my neck.  
 I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.  
 I am able to engage in a few of my usual recreational activities because of pain in my neck.  
 I can hardly do any recreational activities because of pain in my neck.  
 I cannot do any recreational activities at all.

**PATIENT QUESTIONNAIRE**

SF-12

**Instructions:** This survey asks for your views about your health. The information will help keep track of how well you are able to do your usual activities. Please answer each question by marking one box. If you are unsure about how to answer please give the best answer you can.

<b>In general, would you say your health is:</b>				
Excellent	Very good	Good	Fair	Poor

<b>The following questions are about activities that you might do during a typical day. Does your health <u>now</u> limit you in these activities? If so, how much?</b>			
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:	Yes, limited a lot.	Yes, limited a little.	Not limited at all.
Climbing several flights of stairs:	Yes, limited a lot.	Yes, limited a little.	Not limited at all.

<b>During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities as a result of your physical health.?</b>		
Accomplished less than you would like:	yes	no
Were limited in the kind of work or other activities:	yes	no

<b>During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?</b>		
Accomplished less than you would like:	yes	no
Didn't do work or other activities as carefully as usual:	yes	no

<b>During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (including work outside the home and housework)?</b>				
Not at all	A little bit	Moderately	Quite a bit	Extremely

<b>The following questions are about how you feel and how things have been for you during the <u>past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling.</b>					
<b><u>How much of the time during the past 4 weeks...</u></b>					
-have you felt calm and peaceful?	Not at all	A little bit	Moderately	Quite a bit	Extremely
-did you have a lot of energy?	Not at all	A little bit	Moderately	Quite a bit	Extremely
-have you felt downhearted and blue?	Not at all	A little bit	Moderately	Quite a bit	Extremely

<b>During the <u>past 4 weeks</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?</b>				
All of the time	Most of the time	Some of the time	A little of the time	None of the time