

**NEW PATIENT BACK, NECK, SHOULDER AND HIP QUESTIONNAIRE**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_

**Did you have an injury? YES or NO Was this work related? YES or NO**

**Date of injury:** \_\_\_\_\_

**How injury occurred:** \_\_\_\_\_

**Have you seen other physicians for this? YES or NO**

**List names:** \_\_\_\_\_

**What treatment have you had? Please include self treatment. (please circle)**

**NONE**

**Medications (list)** \_\_\_\_\_

**Brace**

**Physical Therapy**

**Home Exercise Program**

**Injections / Shots**

**Have you had any trouble with control of your bladder or bowel? YES or NO**

**Does your pain increase with coughing or sneezing? YES or NO**

**Does your pain increase with?**

**Sitting? YES or NO**

**Standing? YES or NO**

**Laying? YES or NO**

**Have you had any diagnostic testing?**

**X-rays YES or NO**

**MRI YES or NO**

**EMG(nerve studies) YES or NO**

**CT Scan YES or NO**

**Myelogram YES or NO**

**MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOL AND INCLUDE ALL THE AREAS, WHICH ARE AFFECTED:**

**ACHE**  
+++++

**NUMB**  
=====

**PINS/NEEDLES**  
00000000000000

**BURNING**  
XXXXXX

**STABBING**  
////////////////////

