

NEW PATIENT BACK, NECK 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
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NUMB
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PINS/NEEDLES
00000000000000

BURNING
XXXXXXX

STABBING
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