PHYSICIANS' CLINIC
of Iowa, P.C.

ORTHOPAEDIC - BACK QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

A. Main reason for your visit: *(check all that apply)*

☐ Neck Pain ☐ Back Pain

Arms: ☐ Pain ☐ Numbness ☐ Weakness ☐ Other: _____

Legs: ☐ Pain ☐ Numbness ☐ Weakness ☐ Other: _____

How long has the problem been present? _____

Has the problem worsened recently? ☐ Yes When? _____ ☐ No

What started the problem? _____

B. Please complete the section below if you are here to see the doctor about NECK or ARM pain, numbness, or weakness.
If you are seeing the doctor for BACK or LEG pain, proceed to part C.

What percentage of your pain is neck pain and what percentage is arm pain?

☐ 0% Neck and 100% Arm ☐ 30% Neck and 70% Arm ☐ 60% Neck and 40% Arm ☐ 90% Neck and 10% Arm
☐ 10% Neck and 90% Arm ☐ 40% Neck and 60% Arm ☐ 70% Neck and 30% Arm ☐ 100% Neck and 0% Arm
☐ 20% Neck and 80% Arm ☐ 50% Neck and 50% Arm ☐ 80% Neck and 20% Arm

There is arm pain present: ☐ Yes ☐ No If yes, please indicate what percentage of pain is in your right arm versus your left arm?

☐ 0% Right and 100% Left ☐ 30% Right and 70% Left ☐ 60% Right and 40% Left ☐ 90% Right and 10% Left
☐ 10% Right and 90% Left ☐ 40% Right and 60% Left ☐ 70% Right and 30% Left ☐ 100% Right and 0% Left
☐ 20% Right and 80% Left ☐ 50% Right and 50% Left ☐ 80% Right and 20% Left

There is arm ***pain*** present in the:

Right: ☐ Upper Back ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand/Finger
Left: ☐ Upper Back ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand/Finger

Raising the arm: ☐ Lessens the Pain ☐ Worsens the Pain ☐ Does Not Affect the Pain

Moving the arm: ☐ Lessens the Pain ☐ Worsens the Pain ☐ Does Not Affect the Pain

There is ***weakness*** of arms and hands: ☐ Yes ☐ No If yes, please indicate where the weakness is located:

Right: ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand/Finger
Left: ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand/Finger

There is ***numbness*** of arms and hands: ☐ Yes ☐ No If yes, please indicate where the numbness is located:

Right: ☐ Upper Arm ☐ Forearm ☐ Thumb ☐ Index Finger
☐ Long Finger ☐ Ring Finger ☐ Small Finger

Left: ☐ Upper Arm ☐ Forearm ☐ Thumb ☐ Index Finger
☐ Long Finger ☐ Ring Finger ☐ Small Finger

Do you have difficulty picking up small objects like coins or buttons? ☐ Yes ☐ No

Do you have a problem with balance or tripping frequently? ☐ Yes ☐ No

☐ Frequently ☐ Occasionally ☐ None I have headaches in the back of my head.

C. Please complete the section below if you are here to see the doctor about BACK or LEG pain, numbness or weakness. If you are seeing the doctor for neck problems, please complete part B.

What percentage of your pain is back pain and what percentage is leg/buttock pain?

☐ 0% Back and 100% Leg ☐ 30% Back and 70% Leg ☐ 60% Back and 40% Leg ☐ 90% Back and 10% Leg
☐ 10% Back and 90% Leg ☐ 40% Back and 60% Leg ☐ 70% Back and 30% Leg ☐ 100% Back and 0% Leg
☐ 20% Back and 80% Leg ☐ 50% Back and 50% Leg ☐ 80% Back and 20% Leg

There is leg pain present: ☐ Yes ☐ No If yes, please indicate what percentage of pain is in your right leg versus your left leg?

☐ 0% Right and 100% Left ☐ 30% Right and 70% Left ☐ 60% Right and 40% Left ☐ 90% Right and 10% Left
☐ 10% Right and 90% Left ☐ 40% Right and 60% Left ☐ 70% Right and 30% Left ☐ 100% Right and 0% Left
☐ 20% Right and 80% Left ☐ 50% Right and 50% Left ☐ 80% Right and 20% Left

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There is leg ***pain*** present in the:

Right: ☐ Buttock ☐ Thigh-Front ☐ Thigh-Back ☐ Calf ☐ Foot
Left: ☐ Buttock ☐ Thigh-Front ☐ Thigh-Back ☐ Calf ☐ Foot

There is ***weakness*** of the legs: ☐ Yes ☐ No If yes, please indicate where the weakness is located:

Right: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big Toe
Left: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big Toe

There is ***numbness*** of the legs: ☐ Yes ☐ No If yes, please indicate where the numbness is located:

Right: ☐ Thigh ☐ Calf ☐ Foot
Left: ☐ Thigh ☐ Calf ☐ Foot

The worst position for pain is: ☐ Sitting ☐ Standing ☐ Walking

How many minutes can you stand in one place without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

How many minutes can you walk without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

Lying down: ☐ Eases pain ☐ Does not ease pain ☐ Sometimes eases pain

Bending forward: ☐ Increases pain ☐ Decreases pain ☐ Does not affect pain

D. ALL PATIENTS should complete the following questions.

How does coughing or sneezing affect your pain? ☐ Increases Pain ☐ Sometimes Increases Pain ☐ Does Not Increase Pain
Do you have loss of bladder or bowel control? ☐ Yes ☐ No If yes, since when? _____
Have you missed any work because of this problem? ☐ Yes ☐ No If yes, how much work? _____
Have you had any treatment for this problem (Examples: medicines, therapy, manipulations, injections, or braces)? ☐ Yes ☐ No
If yes, please indicate treatments below:

☐ Neck ☐ Back Physical Therapy; Exercise
☐ Neck ☐ Back Massage & Ultrasound
☐ Neck ☐ Back Traction
☐ Neck ☐ Back Manipulation
☐ Neck ☐ Back TENS Unit
☐ Neck ☐ Back Shoulder Injections
☐ Neck ☐ Back Braces

☐ Neck ☐ Back Anti-Inflammatory Medications
☐ Neck ☐ Back Narcotic Medication
☐ Neck ☐ Back Epidural Steroid Injections _____ times, which relieved the pain for *(how long?)* _____
☐ Neck ☐ Back Trigger point injections _____ times, which relieved the pain for *(how long?)* _____
☐ Other _____

Please list pain medications you are been taking. Please include dosages and frequency.

Name of Medication	Dose	Frequency

Please list the names of other health care providers you have seen for this problem:

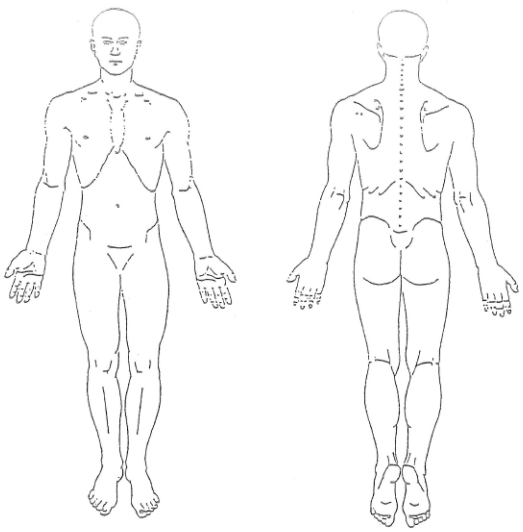
Physician	Specialty	City	Treatments

Please list tests done to evaluate your problem:

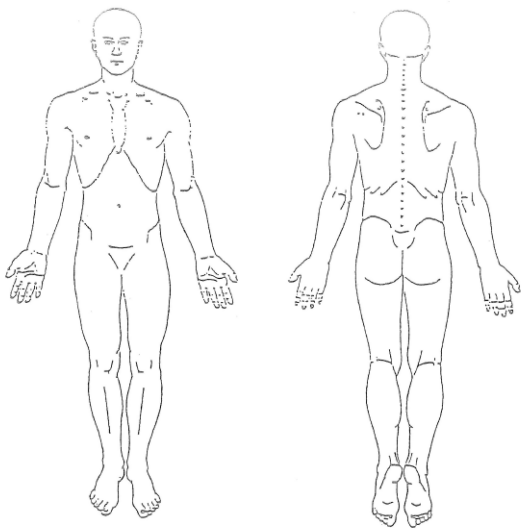
Test	Area	#1 Date	Where?	#2 Date	Where?	#3 Date	Where?
Plain X-Ray	☐ Neck ☐ Back						
Myelogram	☐ Neck ☐ Back						
CAT Scan	☐ Neck ☐ Back						
MRI	☐ Neck ☐ Back						
EMG	☐ Neck ☐ Back						
Bone Scan	☐ Neck ☐ Back						

For each set of figures below, indicate if you have been feeling the described sensations. If you have been feeling the sensations, shade in the areas of the figures where you have been feeling them.

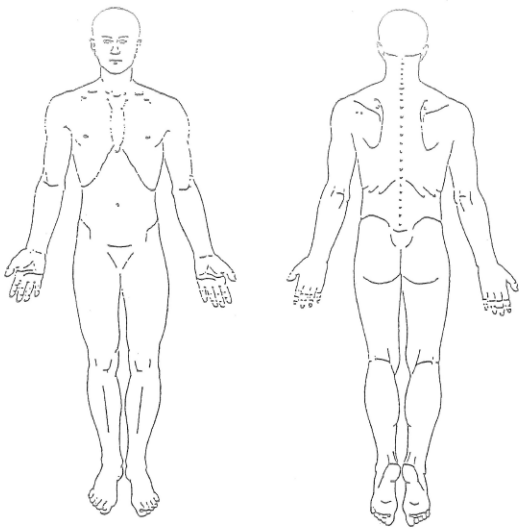
ACHING ☐ No ☐ Yes If yes, please shade areas.



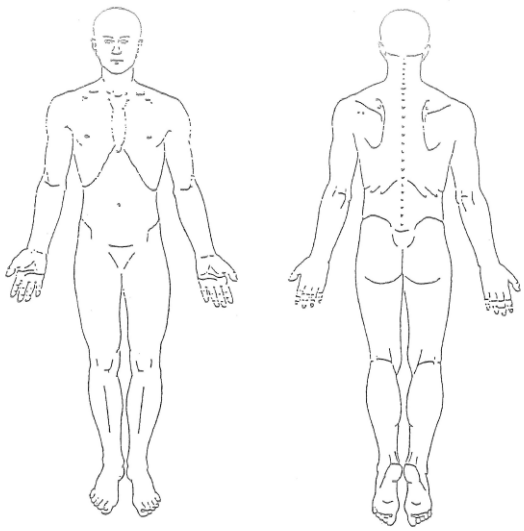
NUMBNESS ☐ No ☐ Yes If yes, please shade areas.



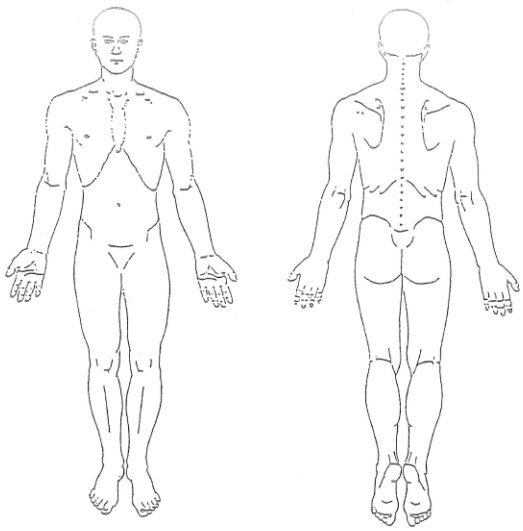
PINS & NEEDLES ☐ No ☐ Yes If yes, please shade areas.



BURNING SENSATION ☐ No ☐ Yes If yes, please shade areas.



STABBING PAIN ☐ No ☐ Yes If yes, please shade areas.



Please indicate your pain/discomfort on the scale below:

1	2	3	4	5	6	7	8	9	10
No pain	Slight	Mild	Moderate	Severe	Excruciating	Pain as bad as it could be			

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____