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? (Total 100%) Neck _____ 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? ☐ Right ☐ Left

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

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

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? (Total 100%) Back _____ 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? ☐ Right ☐ Left

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

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 Anti-Inflammatory Medications
☐ Neck ☐ Back Narcotic Medication
☐ Neck ☐ Back Massage & Ultrasound
☐ Neck ☐ Back Traction
☐ Neck ☐ Back Manipulation
☐ Neck ☐ Back Epidural Steroid Injections _____ times, which relieved the pain for _____
☐ Neck ☐ Back Trigger point injections
☐ 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:

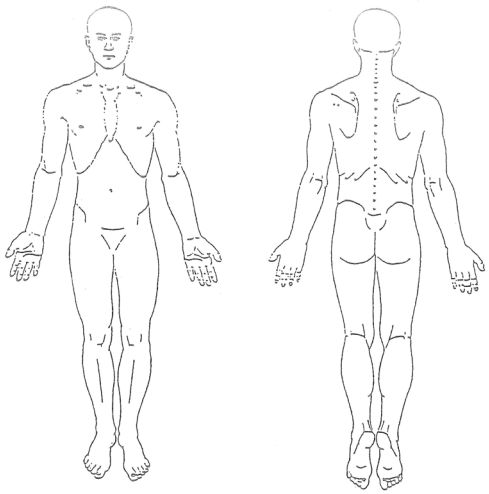
Physician	Specialty	City	Treatments

Please list tests done to evaluate your problem (most recent) :

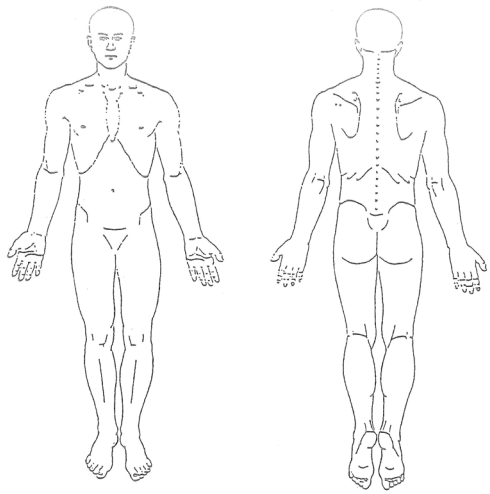
X-Ray	☐ Neck ☐ Back	Date of test: _____	MRI	☐ Neck ☐ Back	Date of test: _____
Myelogram	☐ Neck ☐ Back	Date of test: _____	EMG	☐ Neck ☐ Back	Date of test: _____
CAT Scan	☐ Neck ☐ Back	Date of test: _____	Bone Scan	☐ Neck ☐ Back	Date of test: _____

For each set of figures below, indicate if you have been feeling the described sensations.

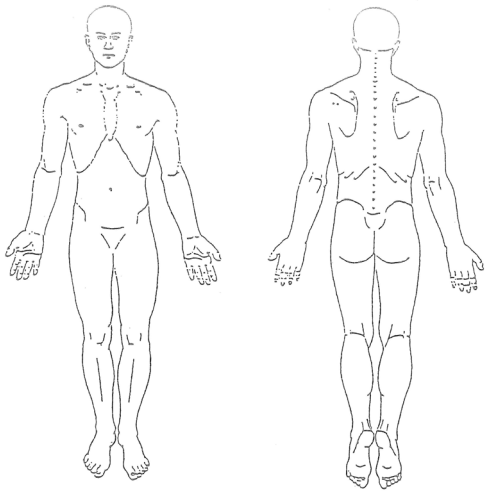
STABBING PAIN ☐ No ☐ Yes If yes, please shade areas.



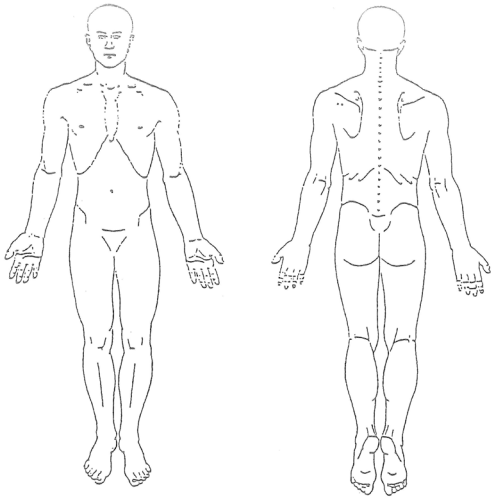
NUMBNESS ☐ No ☐ Yes If yes, please shade areas.



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



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



Please indicate on a scale from 1 to 10 your pain/discomfort:

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

Patient Signature _____ Date _____

Provider Signature _____ Date _____