

PATIENT QUESTIONNAIRE

NAME _____

DATE _____

(1) What is your major complaint today?

- A. Neck Pain
- B. Mid-back Pain
- C. Lower Back Pain
- D. Sciatica
- E. OTHER _____

(2) How did your major complain start? _____

(3) When did you first notice the pain? _____

(4) How would you describe the character of your pain?

- A. Sharp
- B. Dull
- C. Achy
- D. Burning
- E. Shooting
- F. Throbbing
- G. Pins and needles
- H. Tingling
- I. OTHER _____

(5) What makes your pain feel better?

- A. Ice
- B. Heat
- C. Rest
- D. Sitting
- E. Standing
- F. Stretching
- G. Tylenol
- H. Advil
- I. Prescription pain relievers
- J. Nothing
- K. OTHER _____

(6) What makes your pain feel worse?

- A. Bending
- B. Twisting
- C. Lifting
- D. Sitting
- E. Standing
- F. Laying
- G. OTHER _____

(7) Is your pain

- A. Worse in the morning
 - B. Worse in the evening
 - C. Unrelated to the time of day
 - D. OTHER _____
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(8) Do you have a past history of

- A. Diabetes
 - B. Cancer
 - C. Tuberculosis
 - D. Stroke
 - E. Heart Attack
 - F. High blood pressure
 - G. High Cholesterol
 - H. OTHER _____
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(9) Do you have a pacemaker?

- A. Yes
- B. No

(10) Are you pregnant?

- A. Yes
- B. No

(11) What surgeries have you undergone?

- A. Open Heart
 - B. Back Surgery
 - C. Neck Surgery
 - D. Knee Surgery
 - E. Appendectomy
 - F. Tonsillectomy
 - G. Rotator Cuff repair
 - H. OTHER _____
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(12) What types of activities do you engage in on a daily basis?

- A. Prolonged sitting
 - B. Prolonged desk/computer work
 - C. Prolonged standing
 - D. Strenuous physical activity
 - E. OTHER _____
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(13) Would you like us to send a copy of our report to your medical doctor? If yes, please provide the name and address of your medical doctor in the space below.
