

**3 Westbrook Corporate Center
Suite 1000
Westchester, IL 60154
Tel: 708-343-3566**

BACK AND NECK PAIN QUESTIONNAIRE

Please PRINT all information CLEARLY. Note that the last two pages are for Dr. Zelby and Dr. Espinosa's use only.

Date: _____

Name: _____

Please provide exact information below if you were referred by:

- Doctor
- Employer
- Insurance Provider
- Lawyer

Referred by _____

Address _____

Phone _____

BACK AND NECK PAIN QUESTIONNAIRE

Please circle if you are: left handed right-handed

Age _____
M _____ F _____

How and when did your pain begin?

Are your symptoms: ___ **Constant** or ___ **Periodic**?

Do you have numbness, tingling or burning in the leg/foot or arm/hand? **YES** **NO**

Have you experienced any weakness in the leg/foot or arm/hand? **YES** **NO**

What things seem to make your symptoms **worse**? (positions, activities, movements, etc.)

What things seem to make your symptoms **better**? (positions, activities, medication, heat, ice, etc.)

Are you able to drive a car? **YES** **NO**

Are you able to put on your shoes and socks? **YES** **NO**

Does coughing, straining, or sneezing bother you? **YES** **NO**

Please circle the position which is **worst**: **Sitting** **Standing** **Lying down**

Have you had any previous episodes of back/ leg/ neck/ arm pain? **YES** **NO**

If YES, please describe:

Do you have any types of medical problems?

YES NO

If YES, please describe (i.e. diabetes, high blood pressure, heart, lung, kidney problems, etc.)

Have you ever had any type of surgery?

YES NO

If YES, list the type(s) of surgery and date(s):

List the names and amounts of any medications you take:

Are you allergic to any medications?

YES NO

If YES, please list:

What **TREATMENT** have you had for your neck/back problems? What type of response did you have to the treatment?

	No Relief	Some Relief	Good Relief
Bed Rest			
Physical Therapy			
Spinal or muscle injection			
Chiropractic Treatment			
Cervical Neck Collar			
Lumbar Corset or Brace			

BACK AND NECK PAIN QUESTIONNAIRE

Have you ever had any type of tumor: **YES NO**

Have you had any recent fevers, colds or infections: **YES NO**

If YES, please describe:

Have you lost weight over the past 6 months? **YES _____ lbs NO**

Have you experienced difficulty sleeping due to your pain? **YES NO**

Have you suffered headaches in conjunction with your pain? **YES NO**

If YES, how often? _____

Do you have any bowel or bladder problems? **YES NO**

If YES, what type? _____

Do you have any difficulty with sexual function? **YES NO**