SPINESURGERY OF IDAHO
A PIONEER AND LEADER IN EFFECTIVE TREATMENTS

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NECK PAIN QUESTIONNAIRE

THIS MUST BE FILLED OUT COMPLETELY BEFORE YOUR APPOINTMENT

NAME: _____ **AGE:** _____ **SEX:** ☐M ☐F

PRESENT JOB: _____ **FAMILY DOCTOR/INTERNIST**: _____

ONSET OF NECK/ARM PAIN: (Check those that apply)
GRADUAL:_____ SUDDENLY:_____ LIFTING: _____AUTO ACCIDENT:_____BENDING:_____
TWISTING:_____ FROM A FALL:_____ DIRECT BLOW/TRAUMA:_____ **DATE OF ONSET:**_____

NAME OF DOCTOR WHO FIRST TREATED YOU: _____

ARE YOU PRESENTLY WORKING? ☐ YES ☐ NO WHAT DATE DID YOU LAST WORK?_____

OTHER DOCTORS, CHIROPRACTORS, THERAPISTS, ETC. THAT HAVE TREATED YOU:

NAME	DATE	TYPE OF TREATMENT

MY NECK/ARM PAIN IS *WORSE* IN THE:(Check those that apply)
MORNING:_____ AS THE DAY GOES ON:_____ DURING SLEEP HOURS:_____

THERE IS ALSO *NUMBNESS/TINGLING* IN MY:(Check those that apply) NECK: _____ SHOULDERS:_____
LEFT ARM:_____ RIGHT ARM:_____ BETWEEN SHOULDER BLADES:_____

HAVE YOU EVER LOST CONTROL OF YOUR BOWEL/BLADDER SINCE YOUR PAIN BEGAN? _____
FACTORS THAT *DECREASE* MY NECK/ARM PAIN: (Check those that apply) STANDING:_____ WALKING: _____
SITTING: _____ HOT BATH: _____ BENDING MY NECK FORWARD:_____ BENDING NECK BACKWARDS:_____
ANTI-INFLAMMATORY PILLS:_____ MUSCLE RELAXERS:_____ OTHER: _____

FACTORS THAT *INCREASE* MY NECK/ARM PAIN: (Check those that apply)
STANDING: _____WALKING:_____ SITTING: _____DRIVING:_____ COUGHING: _____ SNEEZING: _____
BENDING FORWARD:_____ BENDING BACKWARDS:_____ LAYING ON RIGHT SIDE:____ LAYING ON LEFT SIDE: _____
REACHING OVERHEAD:_____ VACUUMING: _____ OTHER: _____

MY *MOST* COMFORTABLE POSITION/ACTIVITY IS: _____

MY *LEAST* COMFORTABLE POSITION/ACTIVITY IS:_____

DO OTHER FAMILY MEMBERS HAVE NECK/ARM PAIN? ☐ YES ☐NO
IF "YES" PLEASE DESCRIBE:_____

ON A SCALE OF 1-10 (1=NO PAIN, 10=THE WORST POSSIBLE PAIN)**, PLEASE RATE YOUR PAIN:** _____
WHAT MEDICATIONS HAVE YOU USED IN THE PAST THAT *HAVE NOT* WORKED WELL? _____

_____

ALLERGIES OR SENSITIVITIES TO MEDICATIONS: _____

_____

PAST MEDICAL HISTORY

MEDICAL ILLNESSES (PLEASE CHECK THOSE WHICH APPLY TO YOUR HEALTH, PAST & PRESENT)**:**

KIDNEY DISEASE_____ LUNG DISEASE _____ PNEUMONIA _____THYROID _____DIABETES _____
HIGH BLOOD PRESSURE_____IRREGULAR HEART RHYTHM _____CANCER _____ARTHRITIS _____
STROKE _____ HEPATITIS _____ LIVER DISEASE _____ ULCERS _____ RHEUMATIC FEVER _____
OTHER: _____

SURGERY (PLEASE LIST ALL SURGERIES YOU HAVE HAD IN YOUR LIFETIME)**:**

DATE (MONTH/YEAR)	**PROCEDURE** (WHAT KIND OF SURGERY)	**SURGEON**	**LOCATION** (CITY, ST, or HOSPITAL)

FAMILY HISTORY:

	LIVING (YES/NO)	AGE:	CURRENT HEALTH: (GOOD-FAIR-POOR)	DECEASED: (YES/NO)	@AGE:	CAUSE OF DEATH:
MOTHER:						
FATHER:						

	LIVING:	AGES:	CURRENT HEALTH:	DECEASED:	@AGE:	CAUSE OF DEATH:
SIBLINGS #:						
CHILDREN #:						

ILLNESSES THAT RUN IN THE FAMILY: _____

SOCIAL HISTORY:

WHERE WERE YOU BORN? _____ **MARITAL STATUS:** (CIRCLE ONE) *S M D W*
(CITY) (STATE)

DO YOU SMOKE? □ YES □NO, IF "YES" HOW MUCH? _____**OCCUPATION:** _____
DO YOU DRINK? □ YES □NO, IF "YES" HOW MUCH? (PLEASE LIST IN #PER DAY/WK/MO)**:** _____

REVIEW OF SYSTEMS: (PLEASE ***CIRCLE*** ANY OF THE FOLLOWING THAT PERTAIN TO YOUR HEALTH)

CONSTITUTIONAL: WEIGHT LOSS, FEVER, CHILLS, MALAISE

EAR, NOSE, THROAT, & MOUTH: HEARING LOSS, SINUSITIS, SORE THROAT, ORAL CAVITIES, ULCER

GASTROINTESTINAL: NAUSEA, VOMITING, DIARRHEA, CONSTIPATION, ULCER

INTEGUMENTARY: SKIN RASHES, MOLES, DRYNESS, LUMPS, PIGMENTATION

ENDOCRINE: FREQUENT URINATION, EXCESSIVE THIRST, COLD-HEAT TOLERANCE, DIABETES

GENITOURINARY: HEMATURIA, NOCTURIA, MENOPAUSE, HERNIA

HEMATOLOGIC/LYMPHATIC: ANEMIA, BRUISING, BLEEDING, LYMPH NODE ENLARGEMENT

EYES: DOUBLE VISION, BLURRED VISION

CARDIOVASCULAR: CHEST PAIN OR PRESSURE, PALPITATIONS, MURMUR, HYPERTENSION

MUSCULOSKELETAL: ARTHRITIS, JOINT STIFFNESS, SWELLING, MYALGIAS, GOUT

NEUROLOGIC: DIZZINESS, SYNCOPE, SEIZURES, VERTIGO, WEAKNESS, TREMOR

ALLERGIC/IMMUNOLOGIC: ALLERGIES TO MEDICINE, FOOD, DYE, HEPATITIS, HIV

RESPIRATORY: COUGH, HEMOPTYSIS, PLEURITIC CHEST PAIN, WHEEZING, ASTHMA

PSYCHIATRIC: DEPRESSION, AGITATION, PANIC/ANXIETY, MEMORY DISTURBANCE

CURRENT MEDICATIONS: (**Please list all medications, vitamins, and supplements**)

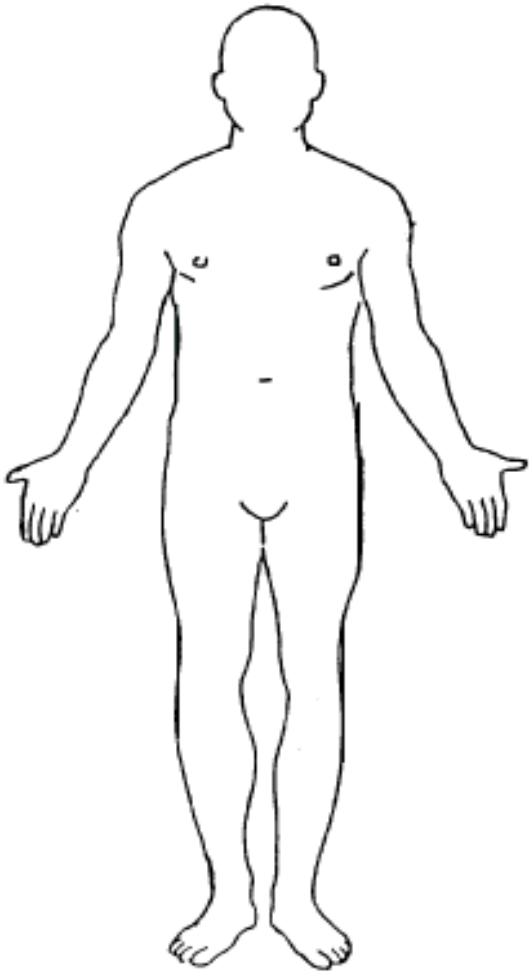
NAME OF MEDICATION	SIZE (MG)	#PER DAY/HOUR	PRESCRIBING DOCTOR

CONTINUE ON OTHER SIDE IF NECESSARY

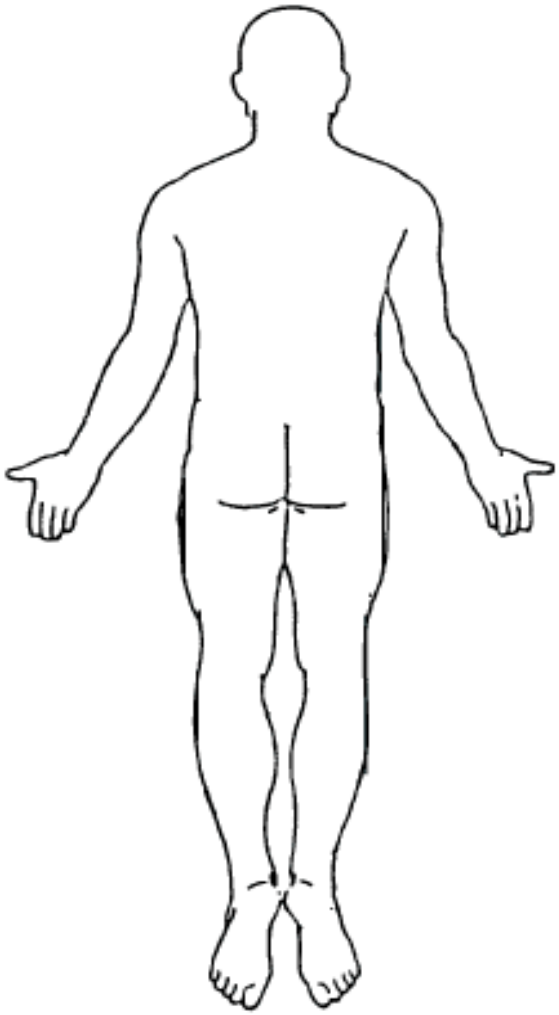
THIS MUST BE FILLED OUT

LISTED BELOW ARE PAIN SENSATIONS. THE SYMBOLS THAT REPRESENT THOSE SENSATIONS FOLLOW THEM. PLEASE DRAW THE SYMBOLS FOR THE APPROPRIATE SENSATION ON THE DIAGRAM BELOW, IN THE PATTERN THAT YOU ARE EXPERIENCING THEM.

STABBING PAIN: ///// **NUMBNESS: +++++** **TINGLING (PINS & NEEDLES): OOOOO**
BURNING SENSATION: BBBBB **ACHING: ΔΔΔΔΔ**



(RIGHT) **FRONT** (LEFT)



(LEFT) **BACK** (RIGHT)

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE COMPLETELY! PLEASE FEEL FREE TO ADD ANY COMMENTS THAT YOU FEEL ARE IMPORTANT ON THE BACK OF THIS PAGE.