ADVANCED spine & care WELLNESS

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515 East Mill Street,
Suite 200
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3424 Superior Avenue
Sheboygan, WI 53081

Date _____

Neck Pain Questionnaire

Name_____ Age____ Occupation_____

1. Date your present pain started? _____. Is there/was there shoulder, arm, forearm, hand pain/numbness? YES / NO L or R

Are you still working? YES / NO If NO, then note your last day you worked _____ expected return date _____

2. How did the pain Start? (Circle all that apply):

Suddenly	Fall	Bending	OTHER _____
Gradually	Pulling	Auto Accident	_____
Lifting	No Apparent Cause		_____
Twisting	Injured during exercise or athletic event		_____

3. What activities make the back pain worse? (Circle all that apply):

Bending head down	Bending head up	Walking	OTHER _____
Sitting	Standing	Morning	_____
Rising from sitting	When Moving	Evening/Night	_____
Exercise	ICE	HEAT	

4. What activities make the back pain better? (Circle all that apply):

Bending forward	Bending Backward	Walking	OTHER _____	
Sitting	Standing	Morning	_____	
Rising from sitting	When Moving	Evening/Night	_____	Massage
Exercise	ICE	HEAT	Acupuncture	NOTHING
REST	Herbs/Supplements	Medications	Chiropractic	Physical therapy

List any Medications, Herbs/Supplements that give relief

_____

_____

5. How long have you had this problem/pain? _____Years _____Months _____Weeks _____Days

6. Circle symptoms you experienced with this problem: Dizziness Nausea Vomiting Fever Double Vision Headache Ringing Ears

7. How many previous episodes? (Circle all that apply): 0 1-5 6-10 11+

8. Is this episode unlike any other before it? YES / NO If NO what helped the last time: _____

9. Circle the studies you have had done **FOR THIS CONDITION** along with the approximate date and place they were performed:

	DATE	**LOCATION & Dr. (If Known)**
None		
X-Rays	_____	_____ _____
CT(Computerized Tomography)	_____	_____
Discography	_____	_____
MRI study	_____	_____
Arthrogram/Sonogram/Ultrasound	_____	_____
Injections or OTHER STUDIES	_____	_____ _____

10. Have you been **hospitalized** for this current pain/condition? YES / NO If YES, then note the date and location.

DATE	**LOCATION & Dr. (If Known)**	**DATE**	**LOCATION & Dr. (If Known)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

11. Have you had **surgery** for this problem? YES / NO Number of Times? _____ List them and **ALL SURGERIES** below.

DATE	**LOCATION & Dr. (If Known)**	**DATE**	**LOCATION & Dr. (If Known)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Rate your general health (Circle one): Excellent Good Fair Poor
13. Do you smoke, chew or use any other tobacco? (Circle one) YES NO If YES, How much? ____x1day/1 week NONE
14. How much caffeine do you use (cups of coffee/ tea, bottles of soda, bottles of energy drinks) ____ x1day/week NONE
15. How much alcohol do you consume?: _____x 1day/1week/1month NONE
16. Any recent motor vehicle or other accidents causing injury/trauma? YES NO
17. Please list your family physician's name and address_____
_____

18. Please list any medications, supplements/herbs that you are taking that you didn't mention in question #4. If you don't remember the name of the drug, list what you are taking it for (example: I take blood pressure pills). **NOTE ALL ALLERGIES HERE.**

_____
_____
_____

Please Circle or note ANY AND ALL other medical conditions you have been treated for:

IN GENERAL
Fever/chills at night,
Swollen Ankles,
Anxiety, Toothache
Frequent Rashes
Hot or Cold Spells
Leg or foot problems
Depression
Numbness in Legs/feet/thighs
Gout

HEART PROBLEMS
Heart Disease
High Blood Pressure
Low Blood Pressure
Chest Pains
Irregular Heart Beat

METABOLIC PROBLEMS
Cancer
Diabetes
Low Blood Sugar
Appetite Changes
Always Thirsty
Unexpected Weight Change
Increased Urination
Thyroid Problems
Obesity/Sedentary Lifestyle

Urinary Problems
Bloody Urine
Frequent Urination
Painful Urination
Night Time Urination (>1)
Trouble Starting Urine
Trouble Stopping Urine

MISCELLANEOUS PROBLEMS
Eye/Vision Problem
Ear/Hearing Problem
Jaw Problem
Difficulty Swallowing
Painful Swallowing
Hoarseness
Change in Voice
Nose Bleeds
Immunity Problems
Chronic infections

LUNG PROBLEMS:
Asthma
Shortness of Breath
Coughing up Blood
Pain with Breathing
Diagnosed COPD
Chronic Pneumonia

STOMACH/GI PROBLEMS:
Blood in Stool
Stomach Problems
Pancreas Problems
Liver Problems
Constipation/Diarrhea
Irritable Bowel Syndrome

NEUROLOGIC PROBLEMS:
Headache
Stroke
Paralysis
Seizures/Epilepsy
Fainting/Blackout
Vertigo

Please note any other medical condition for which you have been treated:_____
_____

Do your Parents, Grand Parents or any Sibling have any of these conditions? Circle the condition(s) that run in your family:
Arthritis, Heart Disease, High Blood Pressure, Cancer, Diabetes, Obesity, Stroke, Crone's Disease, Irritable Bowel Syndrome

_____ _____
Patient's Signature/Parent's if Minor Date

_____ _____
Physician's Signature Date