NECK AND BACK QUESTIONNAIRE

Welcome to the Rainier Orthopedic Institute

Patient Name: _________________ DOB: _______ Date of your visit: _____________

Please read and complete the attached questionnaire. As you answer each section, please be as specific as possible about your condition. Feel free to attach an additional page if you need more room to convey to us what you would like us to know. Your answers, in addition to your examination, will enable us to better reach an accurate diagnosis, assist us in designing a program to meet your specific needs as well as to be used where appropriate in your medical report. Please note that copies of your medical record will be sent to any referring physicians, insurance carriers as appropriate, and to health care professionals who will be directly involved with any care resulting from this back evaluation.
If you receive this questionnaire by mail, please know that it must be completed and brought with you to your initial appointment. Also, please bring along any pertinent diagnostic studies such as **x-rays, CAT scans, MRI scans, EMG studies, etc. relating to your current issue**.

Our staff here looks forward to seeing you and helping you with your medical care. Remember that we all share a common goal . . . Your health and wellbeing.

Once again *welcome*!

Rainier Orthopedic Institute
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You may also visit Rainier Orthopedic Institute at Bonney Lake
20920 State Route 410 E
Bonney Lake, WA 98391
Phone 253-845-9585 Fax 253-862-0419

1. PAIN ONSET

When did your pain begin? _____________________. Please describe briefly what injury it was that occurred to cause you such pain and if a specific incident occurred.

____

____

____

2. HELPFUL TREATMENTS OR RECOMMENDATIONS

Please check the treatments that you have received that have been helpful in relieving you pain.

	Chiropractic		Massage		Hot Packs
	Traction		Tens Unit		Ultrasound
	Ice		Physical Therapy		Back school
	Heat		Epidural/ Facet Blocks		

3. DIAGNOSTIC STUDIES PERFORMED

Please check the studies below that have already been performed.

	None		Discogram		X-ray of spine or neck
	MRI scan		CT scan		Bone scan
	EMG		Myelogram		Other:

4. WORK RELATED INJURY

Is this injury work related? ___________.

If yes, please answer the following questions.

- What is the specific date on which your injury occurred? _____________________
- What is the claim number of this work injury case? ___________________

5. WORK STATUS

Please mark your current work status:

- I am working full time performing all of my regular work activities.
- I am working full time with modified work activities.
- I am working part time at _________ hours a day.
- I have not returned to work since ____.

6. PREVIOUS BACK PROBLEMS OR INJURIES

Have you had a previous back problem or injury? __________

Date of previous injury: _____________________

If yes, please describe when and how this problem or injury occurred (lifting, bending, jumping, etc.) and what kind of injury you sustained. Please include where your pain was located (back, neck, legs, arms, etc.)

____
____
____

7. SURGERIES PERFORMED

Have you had previous spine surgery? ________________
If yes, please answer the following questions.
How many? _______________
When were they performed? ____
What was performed? ____
Who was your surgeon? ____
Did you return to work after the surgery? ______________________________
What work status did you return to?

	Full time at the same job?		Full time at a less strenuous job?
	Part time at the same job?		Part time at a less strenuous job?

Please provide the answers that describe your present abilities and condition.

Is your pain Positional and if so what position alleviates your pain?

____

Is there anything that you note aggravates your pain?

____

8. BODY MECHANICS

- **LIFTING**
  How many pounds are you able to lift? ________________
- **WALKING**
  How long can you walk without pain? _____Minutes _____Hours
- **SITTING**
  How long can you sit without pain? _____Minutes _____Hours
- **STANDING**
  How long can you stand without pain? _____Minutes _____Hours
- **SLEEPING**
  Do you have trouble sleeping at night? _____Yes _____No

9. CONDITION

Has your condition: _____Improved _____Worsened _____Not Changed

10. PAIN RATING

On a scale of 1 to 10, with #1 being the best and #10 being worst please rate you pain level. At its worst the pain is ____/10. Most of the time it's a ____/10. At its best it's a ____/10.

11. LOWER BACK AND LEGS ONLY: (Circle One)

A. 100% back pain and 0% Leg pain
B. 75% back pain and 25% Leg pain
C. 50% back pain and 50% Leg pain
D. 25% back pain and 75% Leg pain
E. 0% back pain and 100% Leg pain

12. **NECK AND ARM PAIN ONLY:** (Circle One)

A. 100% neck pain and 0% arm pain
B. 75% neck pain and 25% arm pain
C. 50% neck pain and 50% arm pain
D. 25% neck pain and 75 % arm pain
E. 0% neck pain and 100% arm pain

Have you been prescribed any narcotic /opioid medication? (i.e. oxycodone, Percocet, Vicodin, etc.) ______Yes or ______No

If yes, who prescribes it? ____

Any Additional information you would like to inform us of?

____
____
____
____
____
____
____

13. BODY DIAGRAM FOR PAIN INDICATION

Using the body diagram below please indicate the location of the sensitivities listed. Mark the areas on the drawing with the symbol that best describes the sensation that you feel.

=== Numbness 000 Pins and Needles xxx Burning /////// Stabbing ^^^^^ Aching