Dr. Cheng's NECK & BACK QUESTIONNAIRE FOR NEW PATIENT

(Please complete this form and bring it with you on your visit)

Last name:_____ First Name:_____ Title: Mr.___ Mrs.___ Dr.___

Appt Date:_____ Refer by:_____

(Please provide name and address of Doctor, of whom you want this report to be send to)

_____

Age:_____ Occupation:_____ Dominant hand: R___ L___

1. **Chief Complaints**: (What is bothering you? What symptoms brought you to see the doctor? For example: severe lower back pain with pain going down to the right leg):

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2. **History of Present Illness**:

When did your back or neck pain originally start?_____ How about leg or arm pain?_____

When did your current episode begin?_____ Did pain start gradually___ or suddenly___

Do you remember any event or cause associated with the initial symptom:_____

(location) ***Where is your discomfort*?** **(check all appropriate box)**
back of head___ Neck___ R. shoulder___ L. shoulder___ R. arm___ L. arm___ Upper back___ Mid back___ lower back___ R. buttock___ L buttock___ R. thigh___ L. thigh___ R. leg___ L leg___ R. foot ___ L. foot___

*(Association)****Radiation of pain*** (example: pain radiate down to top of foot or numbness going down to finger tips): Where?_____ When?_____

(Quality) ***Please characterize the discomfort***:
Numbness___ Pins &needles___ ache___ burning ___Stabbing___ throbbing___

(Severity) ***Pain rating based on scale of 10*** (0= no pain, 10=severe pain that you would rather die)?
Back pain_____ Leg pain_____ Neck pain_____ Arm pain_____

(Timing) **What time of the day is your discomfort worse:**
Morning___ later in the day___ mid. Of the night___ constant without relief___ Random___

This box is to be complete by Physician only.

This entire document has been reviewed by Wayne Cheng, MD

The "Review of System" on page 2&3 has been reviewed by Wayne Cheng, MD. Negative review of system are left blank.

Initial:

***(Factors aggravate or relief the symptoms)*:**	Better	worse	no different
Standing	_____	_____	_____
Walking	_____	_____	_____
Sitting	_____	_____	_____
Bending forward	_____	_____	_____
Bending backwards	_____	_____	_____
Lying flat on back	_____	_____	_____
Lying on my side with knees bent	_____	_____	_____
With cough, sneeze, straining during bowl movements	_____	_____	_____
Activities (vacuuming carpets, mowing lawn)	_____	_____	_____
Exercise (jogging, aerobics)	_____	_____	_____
Cold, damp weather	_____	_____	_____
Heating pack	_____	_____	_____

Self assessment of current condition: How far are you able to walk? _____
How long are you able to stand? _____ How long are you able to sit?_____
Can you continue current occupation? _____

Studies to date: X-ray date:_____ CT date:_____ EMG date:_____
Myelogram date:_____ MRI date:_____ DISCOGRAM Date:_____

Treatment so far (check all appropriate box):
Physical therapy___ Anti-inflammatory medications___ Epidural injection___
Facet injection___ (Was injection done under flouroscopy___yes, ___No, ___ don't know)
cervical traction___ pool therapy___ Brace ___ Chiropractor___ Accupuncture___

If you had prior neck or back surgeries please complete this box:

Date of surg.	Surgeon	Reason for surgery	Type of procedures	Did symptoms improve post-op?

Review of Systems*: *(Check all appropriate, leave line blank if does not apply to you)

1. Neurological:
Do you have difficulty with walking, falling?___ Do you experience clumsiness with your hands? Dropping objects?___ Do you have difficulty control your bowel or bladder?_____

2. Constitutional:
Do you have recent unintentional weight loss?__ Do you have recent fever, chill, night sweats?___

Review of Systems continue: (***check all appropriate, leave line blank if does not apply to you***)

3. Eyes:
Glaucoma___ eye infection___ nearside___ farside___ blurring___ cataract___

4. ***Ear, Nose, throat, mouth***:
Discharge___ ringing in ear___ nose bleed___ dizziness___ infection___

5. Cardiovascular:
Chest pain___ high blood pressure___ heart murmur___ irregular pulse___

6. Respiratory:
Asthma___ bronchitis___ pneumonia___ TB___ chronic cough___

7. Gastrointestinal:
Nausea___ vomiting___ diarrhea___ abdominal pain___ liver problem___
Coughing up blood___ hemorrhoids___

8. Genitourinary:
Painful urination___ kidney stone___ blood in urine___ urinary infection___

9. Musculoskeletal:
Prior fractures___ weakness___ joint swelling/pain___ arthritis___ gout___

10. ***Skin***:
Breast lump___ rashes___ Scar___ nipple discharge___ skin disease___

11. Psychiatric:
Depression___ schizophrenia___ bipolar___ anxiety___ headache___

12. Endocrine:
Diabetes___heat or cold intolerance___ thyroid disease___goiter___

13. Blood:
Anemia___ bleeding tendencies___ easy bruising___ blood transfusions___low platelet___

14. Allergy:
Hives___ itching___

15. Genitoreproductives:
Venereal disease___ discharge___ hernias___menopause___difficulty intercourse___

Past Medical history (example: diabetes, high blood pressure, Panic disorder)

_____

_____

_____

_____

Past Surgical History (other than neck or back surgery)

Date	Surgeon	City	Diagnosis	procedures

Allergies to medication:

Name of medication	Reaction after taken medication

Medication:

Name of medication	Dosage (mg)	# of times per day

Social History:

Marital status?: ___single ___married ___Divorced

How much do you smoke? :___ none, ___yes (# of pack per day_____, # of years_____)

How much do you drink? :_____

Are you currently employeed? ___yes, ___No.

How long have you not been working? (_____)

Is there attorney or litigation involved or in your case? ___yes, ___no.

Family History:

Father ___alive ___deceased Cause of death _____

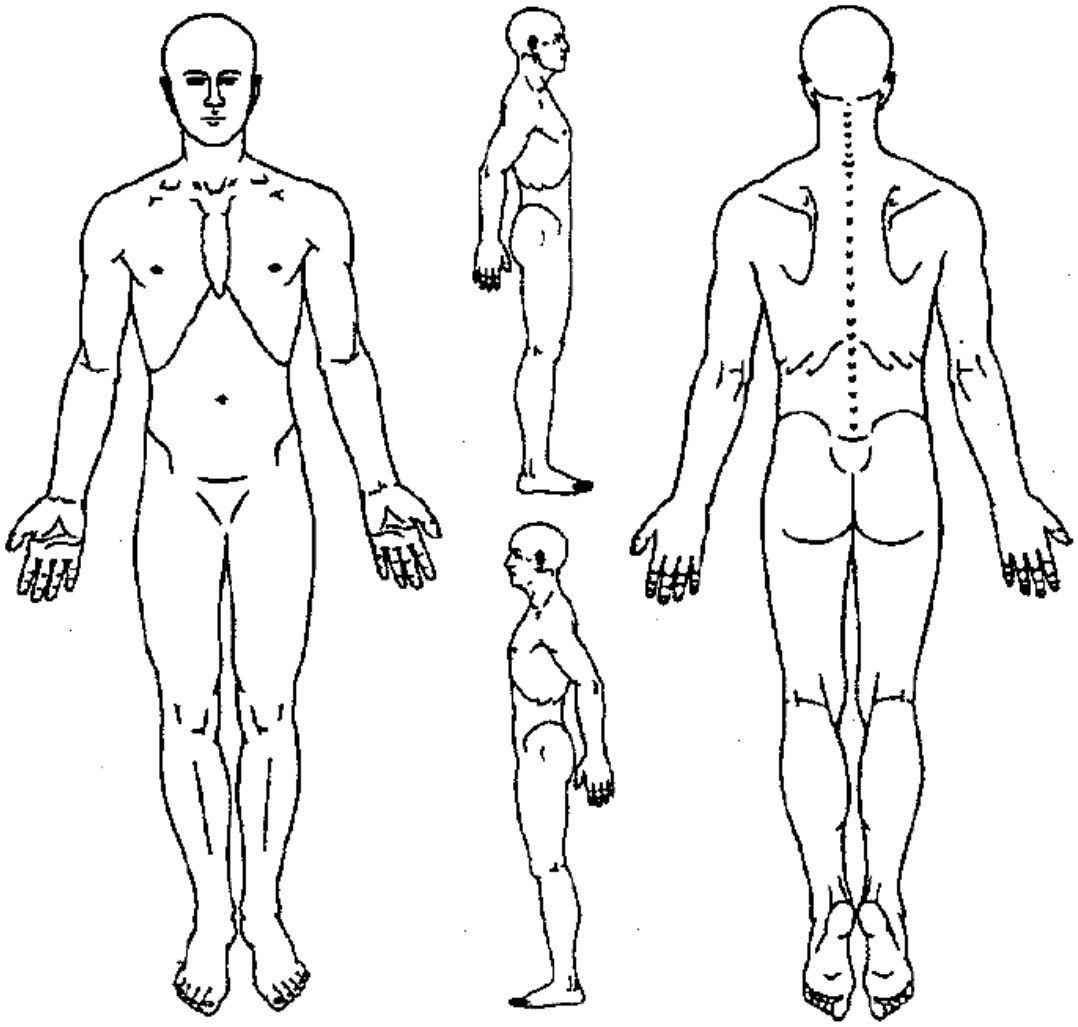
Mother ___alive ___deceased Cause of death_____

Any other disease in the family (exp: bleeding disease,diabetes): _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	**X X X X**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**X X X X**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**X X X X**	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

_____

_____

_____

Date: _____ Signature: _____

Oswestry Low Back Pain Disability Questionnaire Index 2.0

Could you please complete this questionnaire? It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1-pain intensity

- *I have no pain at the moment*
- *The pain is very mild at the moment*
- *The pain is moderate at the moment*
- *The pain is fairly severe at the moment*
- *The pain is very severe at the moment*
- *The pain is the worst imaginable at the moment*

Section 2-Personal Care (washing, dressing, etc.)

- *I can look after myself normally, without causing extra pain.*
- *I can look after myself normally, but it is very painful.*
- *It is painful to look after myself and I am slow and careful.*
- *I need some help, but manage most of my personal care.*
- *I need help everyday in most aspects of self care.*
- *I do not get dressed, wash with difficulty and stay I n bed.*

Section 3-Lifting

- *I can lift heavy weights without extra pain.*
- *I can lift heavy weights, but it gives extra pain.*
- *Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.*
- *Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.*
- *I can lift only very light weights.*
- *I cannot lift or carry anything at all.*

Section 4-walking

- *Pain does not prevent me walking any distance.*
- *Pain prevents me walking more than 1 mile.*
- *Pain prevents me walking more than ¼ of a mile*
- *Pain prevents me walking more than 100 yards.*
- *I can only walk using a stick or crutches.*
- *I am in bed most of the time and have to crawl to the toilet.*

Section 5-Sitting

- *I can sit in any chair as long as I like.*
- *I can sit in my favorite chair as long as I like.*
- *Pain prevents me from sitting for more than 1 hour.*
- *Pain prevents me from sitting for more than ½ hour.*
- *Pain prevents me from sitting more than 10 minutes.*
- *Pain prevents me from sitting at all.*

Section 6-Standing

- *I can stand as long as I want without extra pain.*
- *I can stand as long as I want but it gives me extra pain.*
- *Pain prevents me from standing for more than 1 hour.*
- *Pain prevents me from standing for more than ½ hour.*
- *Pain prevents me from standing for more than 10 minutes.*
- *Pain prevents me from standing at all.*

Section 7-sleeping

- *My sleep is never disturbed by pain.*
- *My sleep is occasionally disturbed by pain.*
- *Because of pain, I have less than 6 hours of sleep.*
- *Because of pain, I have less than 4 hours of sleep.*
- *Because of pain, I have less than 2 hours of sleep.*
- *Pain prevents me from sleeping at all.*

Section 8-Sex Life(if applicable)

- *My sex life is normal and causes no extra pain*
- *My sex life is normal but causes some extra pain*
- *My sex life is nearly normal but is very painful*
- *My sex life is severely restricted by pain*
- *My sex life nearly absent because of pain*
- *Pain prevents any sex life at all.*

Section 9-Social Life

- *My social life is normal and causes me no extra pain.*
- *My social life is normal, but increases the degree of pain.*
- *Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g., sports, etc.*
- *Pain has restricted by social life and I do not go out as often.*
- *Pin has restricted by social life to my home.*
- *I have no social life because of pain.*

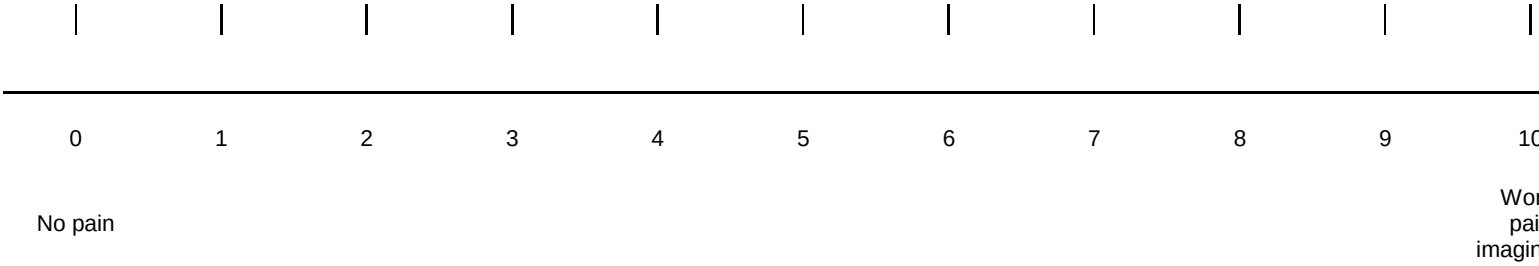
Section 10-Traveling

- *I can travel anywhere without pain.*
- *I can travel anywhere but it gives extra pain.*
- *Pain is bad but I manage journeys over two hours.*
- *Pain restricts me to journeys of less than one hour.*
- *Pain restricts me to short necessary journeys under 30 minutes.*
- *Pain prevents me from traveling except to receive treatment.*

Visual analog Scale:

Please mark a line on the numerical scale to indicate level of your pain
(0 = no pain, 10 = worst pain imaginable)

Numerical Scale

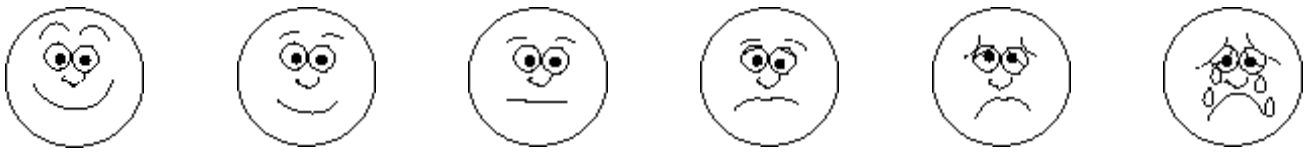


Pain Faces Scale:

Please mark the face that most represent your pain

None (0) Mild (1-3) Moderate (4-6) Severe (7-10)

Pain Faces Scale



0
Very happy, no hurt

2
Hurts just a little bit

4
Hurts a little more

6
Hurts even more

8
Hurts a whole lot

10
Hurts as much as you can imagine (don't have to be crying to feel this much pain)