



FOX VALLEY ORTHOPAEDIC INSTITUTE
FOX VALLEY ORTHOPAEDIC ASSOCIATES, S. C.
2525 KANEVILLE ROAD • GENEVA, ILLINOIS 60134
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BACK-NECK QUESTIONNAIRE

NAME _____ DATE _____

DOB _____ AGE _____ SEX _____ REFERRING DOCTOR _____

PRESENT WORK STATUS

1. Are you employed full or part time, retired, on restricted duty or disabled ? *(circle one)*
2. When did restriction or disability start? _____
3. What is your job description? _____

4. Do you have another job? Yes _____ No _____ *(if yes, explain)* _____

5. Are you right or left handed? *(circle one)*

HISTORY OF PRESENT INJURY/SYMPTOM

1. How did your injury occur? *(car accident, work, sports, fall or other: briefly describe)* _____

2. When did your pain start? _____
3. Did your pain come on suddenly or slowly? *(circle one)*
4. Has your pain gotten better, worse or stayed the same? *(circle one)*
5. Have you had this pain in the past? *(if yes, how often and what were you doing at the time)* _____

6. How long can you stand before having pain? _____ Sit? _____
7. What type of pain are you having? *(circle all that apply)*
sharp dull ripping hot
cold shocking electrical
8. On a scale of one to ten describe your pain, one being no pain and ten being the worst pain? _____

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION, AND INCLUDE ALL AFFECTED AREAS. DRAW IN YOUR FACE.

numbness ---
cold CCC

burning xxx
tingling >>>
pins and needles 000

stabbing ///
sharp pain +++

hot HHH
dull ache \\\

