Bertrand Chaffee Hospital
Springville, NY
Physical Therapy Department

Back and Neck History Questionnaire

Name:___________________________ Date:___________

In your own words, what is your major problem?

What are your present symptoms?

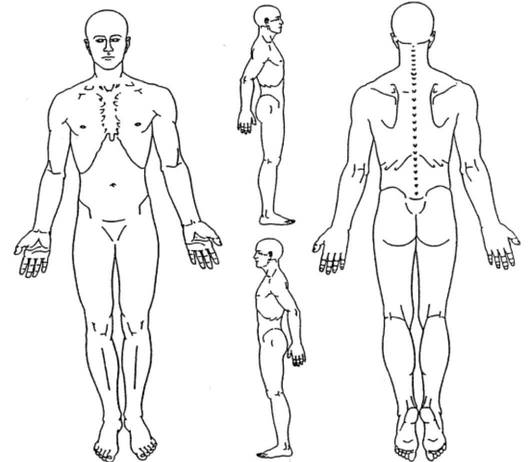
When did this problem begin?
Do you know what might have caused/aggravated the problem?

Has your condition: □ Improved □ Worsened □ Stayed the same
Is your pain: □ Constant □ On/Off
What makes your pain better? □ Being still □ Keeping on the move

Pain is better: □ AM □ As day progresses □ PM
Pain is worse: □ AM □ As day progresses □ PM

Pain is aggravated by: □ Cough □ Sneeze □ Lifting/Straining

Shade in location of pain:



Place 2 marks on the line below, one rating *lowest* level of current pain, and one rating the *highest* level of current pain:
No pain at all ____ Pain as bad as it could be
(BEST) Zero 10 (WORST)

Pain is made worse by: □ Bending □ Sitting □ Standing □ Walking □ Lying down
Pain is made better by: □ Bending □ Sitting □ Standing □ Walking □ Lying down

Do you take medication for this problem? □ No □ Yes List:
If so, does it give you any relief? □ No □ Yes

How do you normally sleep? □ Stomach □ Back □ Right side □ Left side
Does pain interrupt your sleep? □ No □ Yes

Do you have any problem with bowel/bladder function, or loss of sensation in the genital area?
Have you been hospitalized or had surgery for this problem?

What are your goals for treatment?

PAST HISTORY
Have you had similar symptoms before? □ No □ Yes Explain:

Has pain increase in severity or frequency?

Explain how these symptoms are different from previous episodes: