

# SYMPTOM QUESTIONNAIRE (Page 2)

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

## NECK REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Does neck and head movement cause your neck pain to intensify?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
<input type="checkbox"/>	<input type="checkbox"/>	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up? If your difficulty/inability to lift your head without support is injury related, indicate how soon this occurred after injury? ( _____ min/hrs)
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sends pain downwards between your shoulders?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel your neck pain sending pain downwards to the front of your chest?
<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed your head leaning or tilting to one side recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a disc bulge or herniation in your neck?

## ARM, HAND, OR FINGER REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your shoulder, upper arm, lower arm, or hand? Circle areas
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
<input type="checkbox"/>	<input type="checkbox"/>	Do you get increased arm numbness when lying flat on your back* or sleeping on your side recently?*
<input type="checkbox"/>	<input type="checkbox"/>	Does changing your sitting posture increase your arm/hand symptom intensity?
<input type="checkbox"/>	<input type="checkbox"/>	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they improve when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have arm symptoms, do they worsen when you lift your arms over your head? *
<input type="checkbox"/>	<input type="checkbox"/>	If you have night time hand or arm pain, does it help to shake and massage them?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands feel tender when you grasp objects recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel weakness in your grip strength recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you drop objects in your hand recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty writing or doing small motions with your fingers recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hand(s) or wrist get swollen recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do your hands burn recently?
<input type="checkbox"/>	<input type="checkbox"/>	Are your fingers frequently cold?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having Raynaud's syndrome in your past?

\* See commonly asked questions.

## MID BACK AND CHEST WALL REGION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain that shoots or radiates outward along your rib cage?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back or chest wall pain intensify when you take a deep breath in or cough recently?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
<input type="checkbox"/>	<input type="checkbox"/>	When you bend your mid back to the left or right side, does your mid back pain or chest pain increase?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed as having angina before?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a tight band-like chest feeling recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm?
<input type="checkbox"/>	<input type="checkbox"/>	Does your mid back pain mostly bother you during sleep?
<input type="checkbox"/>	<input type="checkbox"/>	Does your upper-middle back pain radiate inwards or upwards into your neck?

## SYMPTOM QUESTIONNAIRE (Page 3)

Please fill out only the sections that apply to you. Skip sections that do not relate to your condition.

### LOW BACK, HIP AND LEG/FOOT REGION

**Check any of the following body movements that intensify your low back pain or leg symptoms:**

<input type="checkbox"/> Sitting	<input type="checkbox"/> Bending forwards	<input type="checkbox"/> Standing up	<input type="checkbox"/> Walking
<input type="checkbox"/> Standing still	<input type="checkbox"/> Bending backwards	<input type="checkbox"/> Lying on your back	<input type="checkbox"/> Putting on shoes

**Check all locations of any current leg pain, numbness, or tingling:**

<input type="checkbox"/> Hip	<input type="checkbox"/> Buttock	<input type="checkbox"/> Back of thigh	<input type="checkbox"/> Calf
<input type="checkbox"/> Groin area	<input type="checkbox"/> Knee	<input type="checkbox"/> Front of thigh	<input type="checkbox"/> Foot/toes

**YES NO Check all areas with a yes or no please**

<input type="checkbox"/>	<input type="checkbox"/>	When you cough, sneeze, or bear down to have a bowel movement, does your low back pain or leg pain get worse recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a consistent pattern of getting severe leg pain after walking for similar distances that is relieved by resting or sitting down. This pain resumes after walking for same distance again. *
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg cramping while walking that is relieved by resting, leaning against an object, or sitting. This pain is worse at night time and is relieved by walking around for a couple of minutes. *
<input type="checkbox"/>	<input type="checkbox"/>	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down. This pain doesn't bother you at night time or while sitting. *
<input type="checkbox"/>	<input type="checkbox"/>	Does your one or both of your legs or feet drag on the floor recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get a lot of leg cramps at night time recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any urinary or bowel incontinence recently or had difficulty urinating or having bowel movements during the same time as your having low back pain or leg pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
<input type="checkbox"/>	<input type="checkbox"/>	Have you observed that your low back pain is not relieved by any type of postural change?
<input type="checkbox"/>	<input type="checkbox"/>	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an injection of Chymopapain into your discs in your back or neck?
<input type="checkbox"/>	<input type="checkbox"/>	Have you recently noticed that either of your legs occasionally give out on you when you walk? *
<input type="checkbox"/>	<input type="checkbox"/>	Does one or both of your legs feel weak recently?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
<input type="checkbox"/>	<input type="checkbox"/>	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
<input type="checkbox"/>	<input type="checkbox"/>	If you have radiating leg or foot pain did you notice low back pain or soreness before your leg symptoms became noticeable?
<input type="checkbox"/>	<input type="checkbox"/>	If you have leg pain, is your leg pain primarily focused in front of your thigh(s)?*
<input type="checkbox"/>	<input type="checkbox"/>	Has your anal-rectal region been completely numb recently?
<input type="checkbox"/>	<input type="checkbox"/>	<b>Men Only.</b> Do you have any recent prostate or urinary problems?
<input type="checkbox"/>	<input type="checkbox"/>	<b>Women Only.</b> Do you have any recent ovarian, uterine, or bladder problems?

\* See commonly asked questions

### SLEEPING PATTERNS

**YES NO**

<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep poorly at night recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you sleep on your stomach?
<input type="checkbox"/>	<input type="checkbox"/>	Do you consistently feel extremely tired when you wake up in the morning recently?