



SUPPLEMENTAL BACK QUESTIONNAIRE

Name:	DOB:
-------	------

Please answer Yes or No to the following questions:

- | | | | |
|----|--------------------------|--------------------------|---|
| | Yes | No | |
| 1) | <input type="checkbox"/> | <input type="checkbox"/> | Do you have back or neck pain now (within past month)? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have back or neck pain most days? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Are you currently being treated for back or neck troubles? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever missed work because of back or neck troubles? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a disability rating related to your back or neck? |
| | | | If yes, give percent disability and name of doctor who determined disability:
_____ % by Dr. _____ |

- | | | | |
|----|--------------------------|--------------------------|---|
| | Yes | No | |
| 2) | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any restrictions related to the back or neck? |
| | <input type="checkbox"/> | <input type="checkbox"/> | Lifting |
| | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged sitting |
| | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged standing |
| | <input type="checkbox"/> | <input type="checkbox"/> | Bending and stooping |
| | <input type="checkbox"/> | <input type="checkbox"/> | Other |
| | | | When were restrictions most recently recommended and by what doctor?
Date: _____ Dr. _____ |

- | | | | |
|----|--------------------------|--------------------------|---|
| | Yes | No | |
| 3) | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever seen the following for back or neck trouble: |
| | <input type="checkbox"/> | <input type="checkbox"/> | Medical Doctor or osteopath |
| | <input type="checkbox"/> | <input type="checkbox"/> | Chiropractor |
| | <input type="checkbox"/> | <input type="checkbox"/> | Back specialist (orthopedist or neurosurgeon) |
| | <input type="checkbox"/> | <input type="checkbox"/> | Physical therapist |
| | <input type="checkbox"/> | <input type="checkbox"/> | Pain clinic |
| | | | If you have seen any of the above, please give date of last visit and with whom:
Date: _____ Name: _____ |

- | | | | |
|----|--------------------------|--------------------------|---|
| | Yes | No | |
| 4) | <input type="checkbox"/> | <input type="checkbox"/> | Have you given up any sports, hobbies or other activities because of back or neck pain? |
| 5) | <input type="checkbox"/> | <input type="checkbox"/> | Do you have or have you ever had numbness or tingling in your arms or legs? |
| 6) | <input type="checkbox"/> | <input type="checkbox"/> | Do you have or have you ever had any shooting pains down your arms or legs? |

7) Please mark any tests that you have had for your back or neck, indicated test results, and when the test was performed:

	TEST	DATE	RE
✓	CT Scan		
	MRI Scan		
	EMG		
	X-ray		
	Myelogram		

8) Place an "X" in the box for any condition which you have or have been told you have:

- | | |
|---|--|
| <input type="checkbox"/> Back pain or trouble | <input type="checkbox"/> Spinal stenosis |
| <input type="checkbox"/> Back Injury | <input type="checkbox"/> Spondylolysis/Spondylolisthesis |
| <input type="checkbox"/> Herniated or ruptured disc | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Disc space narrowing | <input type="checkbox"/> Numbness or weakness in legs |
| <input type="checkbox"/> Abnormal number of vertebrae | <input type="checkbox"/> Pinched nerve |
| <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Broken bone in back or neck |
| <input type="checkbox"/> Collapsed vertebrae | <input type="checkbox"/> Shooting pain in legs |
| <input type="checkbox"/> Neck pain or trouble | <input type="checkbox"/> Degenerative arthritis |
| <input type="checkbox"/> Arthritis in back or neck | <input type="checkbox"/> Whiplash |

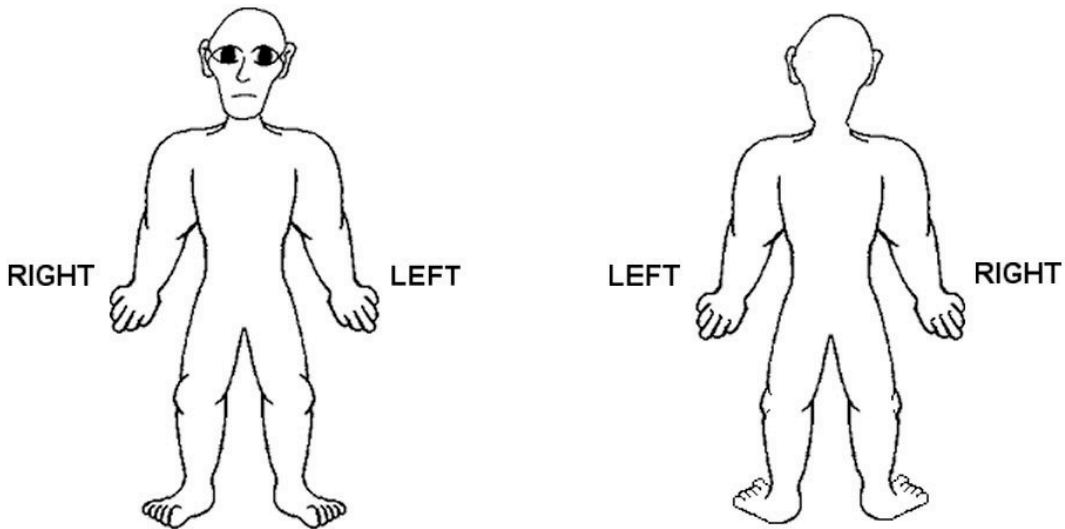
Please explain any condition you marked in question #8 above:

9) Place an "X" in the box for any activity which currently causes back or neck pain:

- | | |
|---|--|
| <input type="checkbox"/> Driving a car | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Washing dishes | <input type="checkbox"/> Catching or throwing a ball |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Running |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Exercising |
| <input type="checkbox"/> Sweeping the floor | |

10) On the diagram below, please:

- Shade the areas where you have had or currently have neck or back pain; and
- Mark with an "X" any areas where you have numbness or tingling:



Signature: _____

Date: _____



OFFICE USE ONLY:

PHYSICAL EXAMINATION

N AB

INSPECTION:

- | | | |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Gait |
| <input type="checkbox"/> | <input type="checkbox"/> | Operative Scars |
| <input type="checkbox"/> | <input type="checkbox"/> | Configuration |
| <input type="checkbox"/> | <input type="checkbox"/> | Symmetry |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |

PALPATION:

- | | | |
|--------------------------|--------------------------|------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Tenderness |
| <input type="checkbox"/> | <input type="checkbox"/> | Spasm |

RANGE OF MOTION:

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Flexion ⇒ _____° |
| <input type="checkbox"/> | <input type="checkbox"/> | Extension ⇒ _____° |
| <input type="checkbox"/> | <input type="checkbox"/> | Lateral bending ⇒ _____° |
| <input type="checkbox"/> | <input type="checkbox"/> | Lateral rotation ⇒ _____° |

NEUROLOGICAL:

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation |
| <input type="checkbox"/> | <input type="checkbox"/> | Straight leg raising |
| | | Right ⇒ _____° Left ⇒ _____° |
| <input type="checkbox"/> | <input type="checkbox"/> | Motor Strength |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee jerk |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle jerk |
| <input type="checkbox"/> | <input type="checkbox"/> | Biceps |
| <input type="checkbox"/> | <input type="checkbox"/> | Triceps |

Impressions/Recommendations:

Signature:

Date:

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