MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL ASSOCIATES

Please complete the following questionnaire:

Name_____ **Date** _____

1. Describe in your own words the nature of your complaint (pain, discomfort, headache, weakness, numbness, etc.).

2. Is your complaint present every day? At night? Only with certain body movements? Does any particular movement initiate discomfort or pain?

3. Does anything make an improvement in your complaint such as rest, avoiding certain activities, medication, etc.? Please describe fully.

4. Describe the initial accident or event leading to your present discomfort. Please include description of the type of work you performed and length of time with your former employer.

5. Are you currently working? Full duty with restrictions or no duty?

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6. Please describe your routine daily activities (bed rest, light activity at home, sports, or sedentary).

7. Please list your previous physicians and their recommendations if you are aware of this information (list dates where possible).

8. In your opinion, is your current complaint improving? Getting worse? At a standstill? Why?

9. Were you ever hospitalized for this condition? How many times and where?

10. Do you now, or have you ever worn a back or neck brace for this condition?