

MASSOUDI AND JACKSON NEUROSURGICAL MEDICAL
ASSOCIATES

Clinical History Patient Questionnaire

Please complete the following:

YOUR NAME: _____ **DATE:** _____

1. When did the pain start? _____
2. Has the pain been increasing recently in... severity? Yes No
...frequency? Yes No
...duration? Yes No
3. Was the onset of pain associated with any trauma, fall, or accident that you can recall?
4. Does repetitive bending or stooping aggravate the pain? Yes No
5. Do you experience stiffness of the back/neck or aggravation of pain after long drives or car rides? Yes No
6. Are you currently claiming, or are you on, any form of job-related disability? Yes No
7. Are you currently involved in a lawsuit against a current or former employer because of work-related injury? Yes No
8. Do you experience any of the following in association with your back or neck pain?
...arm and/or leg numbness Yes No
...burning sensation Yes No
...weakness Yes No
9. Have you experienced any recent onset of unexplained
...urinary incontinence? Yes No
...fecal incontinence? Yes No
(If yes, please explain) _____

10. have you recently experienced any form of sexual dysfunction?
(If yes, please explain) _____

11. What medications have you taken and/or are you taking for the treatment of pain? _____

12. Have you ever tried bed rest as a form of treatment for pain? Yes No
13. Have you ever been involved in a program of physical therapy as part of treatment of your pain? Yes No
14. Have you ever had steroid injections? Yes No
15. Have you had any previous spine operation(s)? Yes No
(If yes, please explain) _____

16. Can you live with the pain and discomfort that you are currently experiencing? Yes No