OIP Orthopedic Institute of Pennsylvania

Dr. Himmelwright Patient Questionnaire Page #1

Name: _____ **Today's Date:** _____

Back / Hip (left or right) / Neck (left or right)

1. If you have pain in one or more areas listed above, please list them in the order of their severity:

A) _____ B) _____ C) _____

1. When did your problems first begin? _____

2. Did you have a specific injury; what _____, when _____
or did it come on gradually?
Please describe: _____

3. How long has your current episode been present? _____
Is it different than previous episodes and if so how? _____

4. Do you have leg symptoms associated with your back or hip pain? YES NO
if yes, which leg? Right Left Both

5. Please describe the intensity of your back / hip /neck pain:
Sharp Dull Ache Stabbing Burning

6. Please describe the duration of your back / hip / neck pain:
Constant Only with activity Occasional Infrequent

7. Do you have any percieved muscle weakness in the lower extremities? YES NO

8. Do you have any precieved muscle weakness in the upper extremities? YES NO

9. Do you have any Numbness or Tingling (Pins and needles) in the lower extremities? YES NO

10. Do you have any Numbness or Tingling (Pins and needles) in the upper extremities? YES NO

11. What activities make your symptoms worse?
Sitting Driving Standing Walking Bending Lifting Lying down Reaching Grasping
Other _____

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12. What makes your symptoms better?
Sitting Standing Walking Lying down Ice
Heat - Massage Hot shower or bath
Other _____
_____

13. What types of treatments have you had for this to date?

Medications
(please list) _____

____ Chiropractic Treatments
(please list) _____

____ Physical Therapy
(when and where) _____

____ Osteopathic Manipulation
(please list name) _____

____ Oral or Epidural Steroid injections
(when and where) _____

____ Previous Orthopedic or Neurosurgeons Consultations
(when, where and with whom) _____

____ Previous Surgical Procedures
(when, where, what was done and by whom) _____

14. Does coughing or sneezing change the intensity of your pain?
YES NO Worse Better

15. Have you had any changes in your bowel or bladder function? YES NO
If yes please describe _____

16. If your back/neck/hip problems were related to an injury was it work related? YES NO
If yes has it affected your ability to perform your job? YES NO
Are you still working? YES NO
If no what was the date you last worked:

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17. On the diagrams below please document where you experience your

Pain using the letter "P"
Numbness "N"
Tingling "T"
Burning using the letter "B"