

IDD Therapy® Patient Questionnaire

1. Where is your current pain located? PLEASE CIRCLE ALL RESPONSES.

Lower back	neck	foot	shoulder	leg	arm
Indicate Left or Right:	L R	L R	L R	L R	L R

2. How long have you had this pain?

1-3 months	4-6 months	7-12 months	>1yr
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3. Have you ever experience radiating of any pain now or in the past? YES NO

4. Have you ever been diagnosed with a ruptured, herniated, or bulging disc, Sciatica, Stenosis or Degenerative Disc Disease? YES NO

If "YES," where was the condition located? \_\_\_\_\_

5. Have you had any of the following diagnostics preformed? If so, how long ago?

MRI	1-3 months	4-6 months	7-12 months	>1 yr
CAT/CT scan	1-3 months	4-6 months	7-12 months	>1 yr
X-ray(s)	1-3 months	4-6 months	7-12 months	>1 yr

6. Have you ever had low back surgery? YES NO

What type of surgery have you had? (Circle below)

Laminectomy	Discectomy	Fusion	Other _____
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7. Do you have any metal or hardware in your spine? YES NO

If so, where? \_\_\_\_\_

8. Did you have hardware previously, but had it removed? YES NO

How long ago?	1-3 months	4-6 months	7-12 months	>1yr
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9. Do you have trouble doing daily activities such as walking, bending, stooping, sleeping or sitting? YES NO

Which one is the most difficult? (Circle it in the list above). How long can you maintain this activity before pain forces you to stop? \_\_\_\_\_

