

D6 Back/Neck questionnaire – ONLY complete if you have answered **yes to question 6 in **Section C1****

1. When did your back/neck condition first occur?

DD / MM / YYYY

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash)

5. Was an x-ray, CT scan or any other type of investigation performed?

Yes ☐ No ☐

If **other**, please provide details

Tests

Results

Date of tests

DD / MM / YYYY

DD / MM / YYYY

6. Have you had recurrent or multiple episodes of the back/neck condition?

Yes ☐ No ☐

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration

7. Please provide details of all people you have consulted for this condition, in the table below

Name and address of
doctor/health professional

Type
(e.g. doctor, chiropractor,
physiotherapist)

Date last
consulted

Treatment prescribed
(e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)

DD / MM / YYYY

DD / MM / YYYY

DD / MM / YYYY

8. Have you had any time off work due to this condition?

Yes ☐ No ☐

If **yes**, please provide the dates and duration

Date DD / MM / YYYY Duration

Date DD / MM / YYYY Duration

9. Are your work duties or activities limited/affected by the condition?

Yes ☐ No ☐

If **yes**, please provide details

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind?

Yes ☐ No ☐

If **yes**, please provide details

11. Overall do you feel that your back/neck condition is:

Resolved ☐

Improving ☐

Stable ☐

Deteriorating ☐

12. What was the date of your last symptoms?

DD / MM / YYYY

GO BACK TO SECTION C1