Name: ______________________

Date of Birth: ______________________

Date of Visit: ______________________

Referring Doctor: ______________________

DOB: ______________________ Age: ________ Sex: M / F

Height: ____________ Weight: ____________ Marital Status: S M D W

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Tell us about your symptoms

Date of injury: ______________________

What are your symptoms? ______________________

Is this pain mostly in back, neck or elsewhere? ______________________

How long ago did the symptoms begin? ______________________

Is the pain constant, or does it come and go? ______________________

How do these symptoms limit you? ______________________

What things make the pain better(rest, ice, heat, pills)? ______________________

What makes the pain worse? ______________________

Do you have pain that radiates into the arm or leg?

☐ Yes ☐ No Describe: ______________________

Have you lost any control over bowel or bladder functions?

☐ Yes ☐ No Describe: ______________________

Do you have any weakness or numbness in an arm or leg?

☐ Yes ☐ No Describe: ______________________

How long can you: sit ________ stand ________ walk ________

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Injury on the job

☐ Other: ______________________

Which of the following describes you currently?

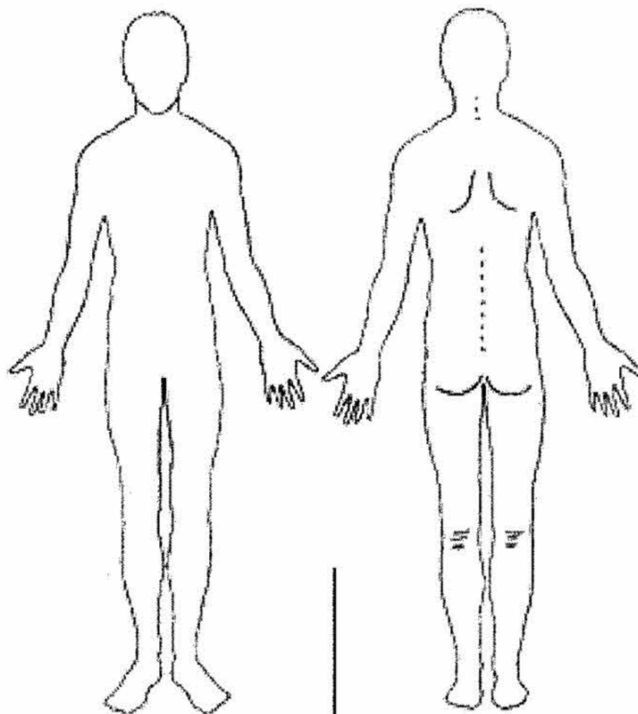
- ☐ Working
- ☐ Not working because of back or neck problem
- ☐ Not working because of another health problem
- ☐ Homemaker, retired or unemployed

How long have you been at that job? ______________________

Does your job require lifting, standing, sitting? ______________________

Employer at time of injury ______________________

Is there a law suit pending on problem? ☐ Yes ☐ No




| | Front | | Back |
|---|---|---|---|
| Stabbing pain | //// | Stabbing pain | //// |
| Burning pain | oooo | Burning pain | oooo |
| Aching pain | xxxx | Aching pain | xxxx |
| Numbness | ==== | Numbness | ==== |

Circle your pain level on a scale of 1 to 10, with 10 being unbearable, or worst imaginable, pain.

1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

Name: ____________________
Date of Birth: ____________________
Date of Visit: ____________________

Name: ____________________
Date of Birth: ____________________

Who treated you first for this problem? Dr. ____________________ City: ____________________

What treatment did you have then? ____________________

What tests have you had? ☐ CT Scan ☐ MRI ☐ X-ray ☐ EMG

☐ Other ____________________

Did you have any injections for your problem?

☐ Yes ☐ No Describe ____________________

Did these injections help?

☐ Yes ☐ No Describe ____________________

Did you have previous back or neck surgery?

☐ Yes ☐ No Describe ____________________

Did you have physical therapy for your problem?

☐ Yes ☐ No Describe ____________________

Did this therapy help?

☐ Yes ☐ No Describe ____________________

Do you do any special exercises for your back or neck? ____________________

Have you tried anything else for the pain? ☐ No ☐ Ice ☐ Brace ☐ Therapy ☐ Chiropractic ☐ Massage

What are the hobbies/sports that you participate in ____________________

Does your pain limit your participation in these? ☐ Yes ☐ No How? ____________________

Do you have pain at rest? ☐ Yes ☐ No

Do you have pain at night? ☐ Yes ☐ No

Have you taken any medication for the pain? ☐ Yes ☐ No List ____________________

What do you hope we can accomplish today? ____________________