BACK

REFERRED BY: Doctor: □ Former Patient: □ Phone Book: □ Internet: □ Ins. Co: □

Referring Doctors Name/address & Phone #_____

Family Doctors name/address & Phone #:_____

Other Doctors name/address & Phone #:_____

Present Illness**: PLEASE CIRCLE ALL THAT APPLY**

Low back pain: Y N pain is: mild/moderate/severe/excruciating/dull/sharp/constant

Any radiation of pain? Y N into: buttock/thigh/groin/ hip/leg/ankle/foot/toes (big toe/ little toe/ heel)

(left,right,bilateral)

Is radiation: mild/moderate/severe/excruciating/dull/sharp/constant

Any? Aching/burning/tingling/numbness/stiffness/ weakness

If yes location: buttock/thigh/groin/ hip/leg/ankle/foot/toes (big toe/ little toe/ heel) **(left,right,bilateral)**

Date of onset:_____ Injury related: yes no How_____

Symptoms began with: lifting/ work accident/ auto accident/ other liability/ spontaneous/ awoke with symptoms/gradual onset/ other:_____

Symptoms **aggravated** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/ sex/ sleeping/ resting/ urination/ bowel movements

Symptoms **improved** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/ sex/ sleeping/ resting/ urination/ bowel movements

Any other associated symptoms?: chest pain/ headache/ bowel or bladder disturbance/abdominal pain

Any other symptoms? No yes: nausea/ constipation/ urinary urgency/ other_____

Treatments tried: none/ anti-inflammatory/ narcotics/ muscle relaxants/ antidepressants/ physical therapy Epidural steroid injections/ pain injections/ chiropractor/ massage therapy/ Acupuncture/ nerve injections/ facet injections/ surgery

Are activities restricted? No yes: limited working/ not working/ limited housework/ no housework limited sports activity/ no sports activity/yard work/ shopping/ no exercising/ limited exercising/other_____

Any prior history of above complaints? No Yes: -if yes- How long_____

Explain prior complaints:_____

Tests performed: none/ spine x-ray/ EMG/ nerve conduction studies/ CT scan/ MRI/ myelogram and CT scan/ PET scan/ bone scan/ bone density/ diskogram/ facet injection/

NECK

REFERRED BY: Doctor: □ Former Patient: □ Phone Book: □ Internet: □ Ins. Co: □

Referring Doctors Name/address & Phone #_____

Family Doctors name/address & Phone #:_____

Other Doctors name/address & Phone #:_____

Present Illness**: PLEASE CIRCLE ALL THAT APPLY**

Neck pain: Y N pain is: mild/moderate/severe/excruciating/dull/sharp/constant

Any radiation of pain/aching/burning? Y N into: shoulder/ scapula/ chest/ upper arm/ elbow/ forearm/ hand fingers (thumb/ index/ middle/ ring/ little)/back of head **(left,right,bilateral)**

is radiation: mild/moderate/severe/excruciating/dull/sharp/constant

Any? Tingling/numbness If yes location: shoulder/ scapula/ chest/ upper arm/ elbow/ forearm/ hand fingers (thumb/ index/ middle/ ring/ little)/ **(left,right,bilateral)** /genitals

Any? Weakness/stiffness If yes location: grip/fingers/arms/hands/legs **(left,right,bilateral)**

Date of onset:_____ Injury related: Yes No How_____

Symptoms began with: lifting/ work accident/ auto accident/ other liability/ spontaneous/ awoke with symptoms/gradual onset/ other:_____

Symptoms **aggravated** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/ sex/ sleeping/ resting/ urination/ bowel movements

Symptoms **improved** by: lying/ sitting/ standing/ bending/ climbing/ working/ driving/ walking/ sex/ sleeping/ resting/ urination/ bowel movements

Any other associated symptoms?: chest pain/ headache/ bowel or bladder disturbance/ difficulty with walking or balance/falling/double vision/ ringing in ears/

Any other symptoms? No Yes: _____

Treatments tried: none/ anti-inflammatory/ narcotics/ muscle relaxants/ antidepressants/ physical therapy Epidural steroid injections/ pain injections/ chiropractor/ massage therapy/ Acupuncture/ nerve injections/ facet injections/ surgery

Are activities restricted? No Yes: limited working/ not working/ limited housework/ no housework limited sports activity/ no sports activity/yard work/ shopping/ no exercising/ limited exercising/ driving /other_____

Any prior history of above complaints? No Yes: -if yes- How long_____
Explain prior complaints:_____

Tests performed: none/ spine x-ray/ EMG/ nerve conduction studies/ CT scan/ MRI/ myelogram and CT scan/ PET scan/ bone scan/ bone density/ diskogram/ facet injection/ nerve injection