SPINE HISTORY

Chief complaint □Neck/Upper Extremity (Arm) Pain/Symptoms □Back/Lower Extremity (Leg) Pain/Symptoms

Spinal Deformity (if known) □SCOLIOSIS □KYPHOSIS □OTHER_____
How was deformity discovered? _____ Curve Measurement? (if known)_____

When did the pain start?	Did the pain start? □gradually □suddenly
How did it start? □Auto Accident □Fall □Lifting □Bending □Pulling □Twisting □Hit in Back □Other_____	Because of this spine problem, I have filed or plan to file: □A Lawsuit □A Worker's Compensation Claim □Other_____

NECK/UPPER Extremity (ARM) Pain/Symptoms

Do you have arm pain? □Yes □No □Left □Right □Both	Do you have numbness in your arm(s)? □Yes □No □Left □Right □Both
What percentage is **ARM** pain vs. **NECK** pain?	_____%**ARM** _____%**NECK** = 100%
What percentage is **RIGHT** arm pain vs. **LEFT** arm pain?	_____%**LEFT** _____%**RIGHT** = 100%

BACK/LOWER Extremity (LEG) Pain/Symptoms

Do you have LEG pain? □Yes □No □LEFT □RIGHT □BOTH	Do you have numbness in your LEG(S)? □Yes □No □LEFT □RIGHT □BOTH
What percentage is **BACK** pain vs. **LEG** pain?	_____%**BACK** _____%**LEG** = 100%
What percentage is **RIGHT** LEG pain vs. **LEFT** LEG pain?	_____%**RIGHT** _____%**LEFT** = 100%

MY PAIN IS:	
With cough or sneeze	□BETTER □WORSE □NO DIFFERENT
Sitting	□BETTER □WORSE □NO DIFFERENT
Bending Forward	□BETTER □WORSE □NO DIFFERENT
Bending Backwards	□BETTER □WORSE □NO DIFFERENT
Lying on Back	□BETTER □WORSE □NO DIFFERENT
Standing	□BETTER □WORSE □NO DIFFERENT
Walking	□BETTER □WORSE □NO DIFFERENT

HAVE YOU HAD?	
NSAIDs	□Yes □No □BETTER □WORSE □NO DIFFERENT
Narcotic Medications	□Yes □No □BETTER □WORSE □NO DIFFERENT
Muscle Relaxants	□Yes □No □BETTER □WORSE □NO DIFFERENT
Physical Therapy	□Yes □No □BETTER □WORSE □NO DIFFERENT *Duration of Treatment*:_____
Chiropractic Treatment	□Yes □No □BETTER □WORSE □NO DIFFERENT *Duration of Treatment*:_____
Home Exercise Program	□Yes □No □BETTER □WORSE □NO DIFFERENT
Bracing	□Yes □No □BETTER □WORSE □NO DIFFERENT
Injections	□Yes □No □BETTER □WORSE □NO DIFFERENT *Duration of Treatment*:_____
Who did the injections?	
Back/Neck Surgery	□Yes □No □BETTER □WORSE □NO DIFFERENT

HAVE YOU HAD ANY OF THE FOLLOWING FOR YOUR BACK/NECK?

	# OF TIMES	**DATES**	**DOCTOR/FACILITY**
Hospitalization			
MRI			
X Rays			
CT Scan			
Myelogram			
EMG			
Bone Scan			
Discogram			

PATIENT NAME_____ **DOB**_____ **DATE**_____

MY PAIN / DISCOMFORT LEVEL IS (circle number)

☐0 ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10

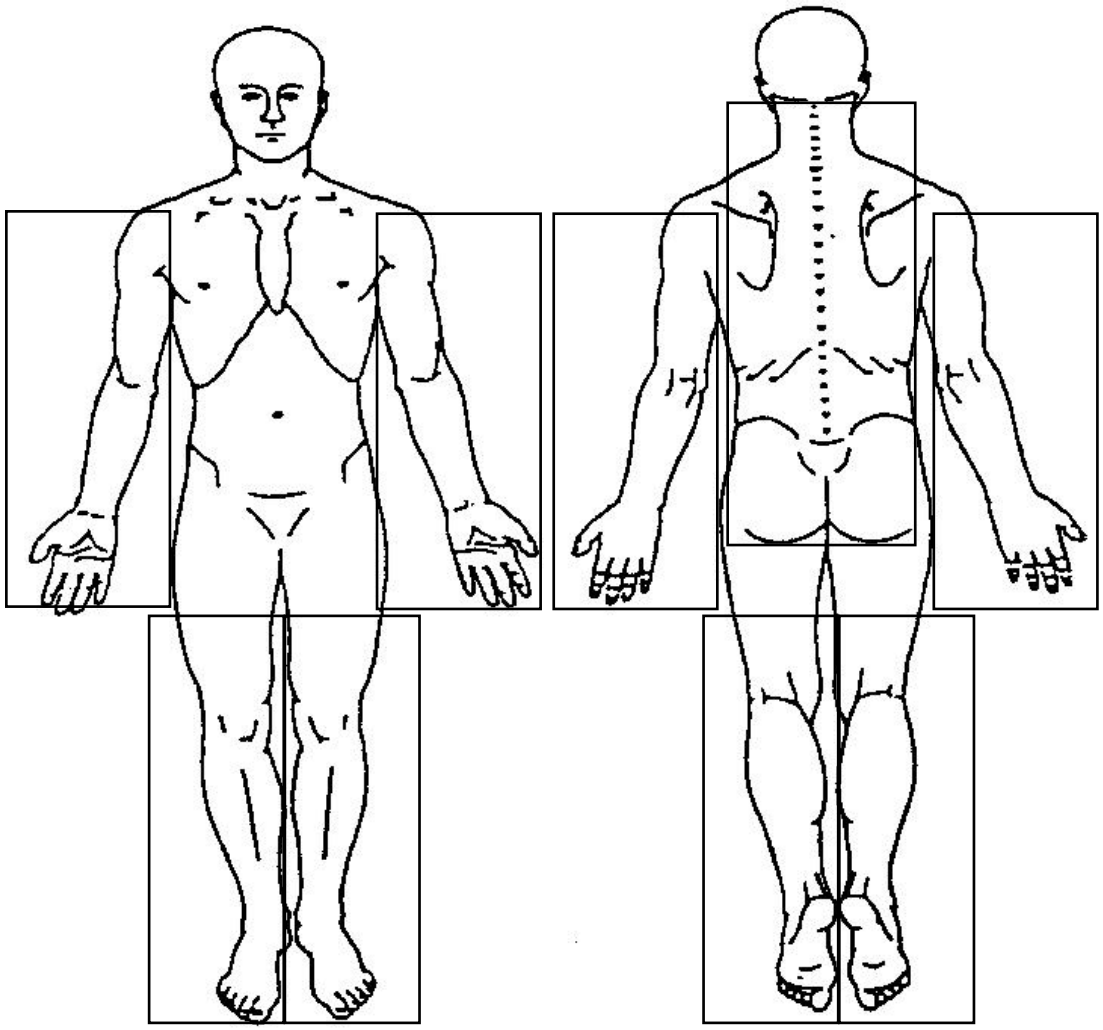
(0= No Pain and 10=Severe Excruciating Pain as bad as it could be)

Please fill in the drawing below:

Use the symbols on the diagrams below to show the type of pain you feel.

Stabbing Pain //// **Pins & Needles VVVV** **Burning Pain OOOO**

Numbness - - - - - **Aching Pain XXXX**



Please take the time to review the questionnaire for completeness.

_____

Signature of Patient/Legal Guardian

PATIENT NAME_____ **DOB**_____ **DATE**_____