

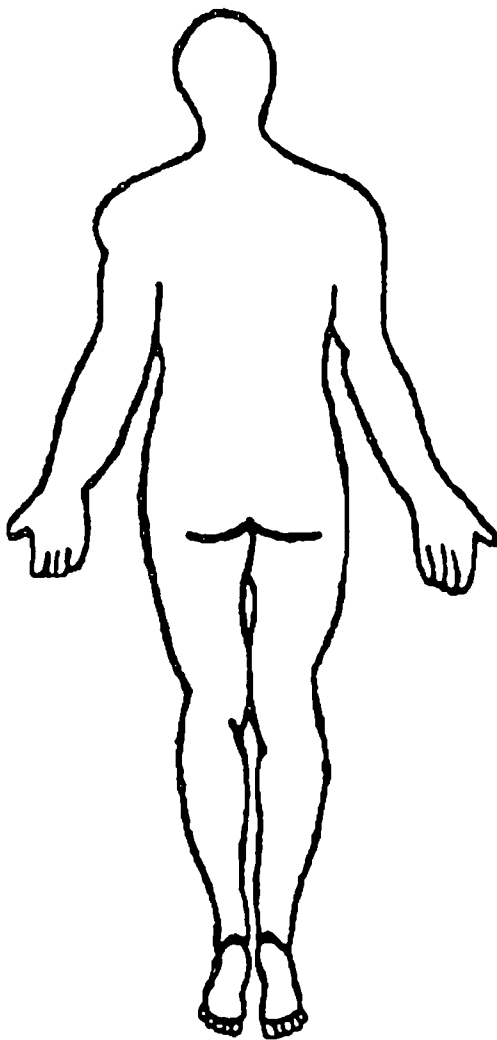
NAME: _____

DATE: _____

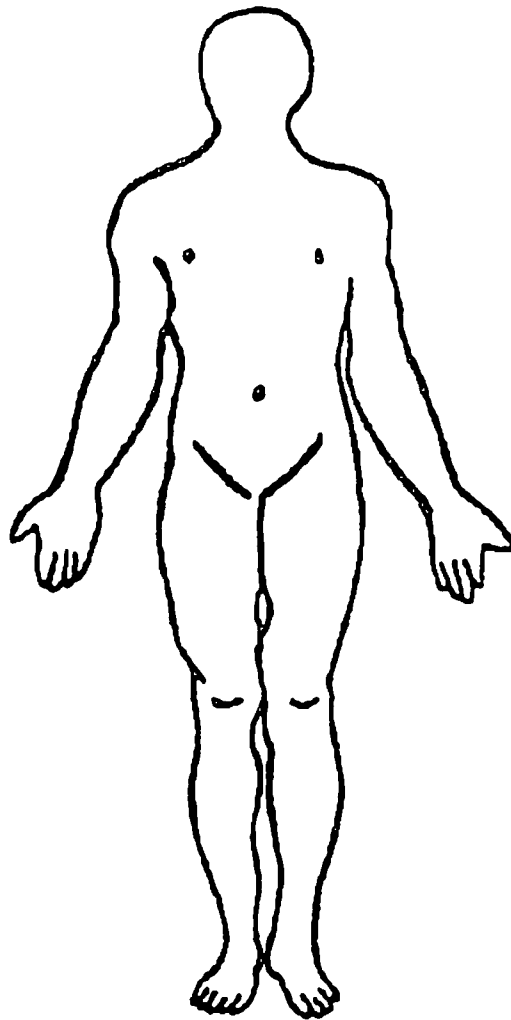
PLEASE GIVE THIS PAPER TO THE DOCTOR AT THE TIME OF THE EXAMINATION

**Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.
Mark the areas of radiation. Includes all affected areas. To complete the picture, please draw in your face.**

NUMBNESS (—) PINS & NEEDLES (0000) BURNING (xooo) STABBING (////)



BACK



FRONT



SPINE SELF ASSESSMENT

Name: _____
Age: _____

PRESENT PAIN EPISODE:

ONSET:

IS YOUR PROBLEM THE RESULT OF AN INJURY? Y N
IS THIS INJURY WORK RELATED? Y N
IS LEGAL ACTION PENDING? Y N

WHEN DID THE CURRENT EPISODE BEGIN? _____

HOW DID THE EPISODE BEGIN? (CHECK ONE)

- _____ 1. SUDDENLY
_____ 2. GRADUALLY

INDICATE THE SEVERITY OF PAIN DURING THIS EPISODE (CIRCLE NUMBER REPRESENTING THE WORST AND AVERAGE PAIN)

BACK/NECK

LEG/ARM

WORST:	0	1	2	3	4	5	0	1	2	3	4	5
	no	very	mild	moderate	severe	very	no	very	mild	moderate	severe	very
	pain	mild				Severe	pain	mild				severe
AVERAGE:	0	1	2	3	4	5	0	1	2	3	4	5

HAS THE AMOUNT OF YOUR PAIN BEEN CHANGING?

- _____ 1. GETTING WORSE (MORE PAIN)
_____ 2. GETTING BETTER (LESS PAIN)
_____ 3. ABOUT THE SAME

DURING THIS EPISODE MY LOW BACK(NECK) HURTS:

- _____ 1. ALL THE TIME
_____ 2. MOST OF THE TIME
_____ 3. SOME OF THE TIME
_____ 4. NO BACK(NECK) PAIN

DURING THIS EPISODE MY LEG(ARM) HURTS:

- _____ 1. ALL THE TIME
_____ 2. MOST OF THE TIME
_____ 3. SOME OF THE TIME
_____ 4. NO LEG(ARM) PAIN

HAVE YOU LOST CONTROL OF BOWEL OR BLADDER?

- _____ 1. YES
_____ 2. NO

DO THE FOLLOWING FACTORS MAKE YOUR PAIN BETTER, WORSE OR NO DIFFERENT? (CHECK ONE FOR EACH FACTOR)

	BETTER	WORSE	NO DIFFERENT
1. BENDING	_____	_____	_____
2. LIFTING	_____	_____	_____
3. TWISTING	_____	_____	_____
4. SITTING	_____	_____	_____
5. WALKING	_____	_____	_____
6. COUGH/SNEEZE	_____	_____	_____
7. LAYING	_____	_____	_____

HOW FAR CAN YOU WALK? _____

PAST SPINE HISTORY

LOW BACK(NECK) HISTORY:

PREVIOUS EPISODES OF BACK PAIN?

1. NO - GO TO NEXT SECTION
2. YES

HOW LONG AGO WAS THE LAST EPISODE?

1. LESS THAN ONE YEAR AGO
2. 1-2 YEARS AGO
3. 2-3 YEARS AGO
4. MORE THAN 3 YEARS AGO

HOW MANY OTHER EPISODES OF PAIN IN THE PAST?

1. 1
2. 2
3. 3
4. 4-10
5. GREATER THAN 10

PREVIOUS TREATMENT (CIRCLE ALL THAT APPLY)

1. NON NARCOTIC MEDICATION
2. NARCOTIC MEDICATION
3. PHYSICAL THERAPY
4. EPIDURAL STEROIDS
5. CHIROPRACTIC
6. PAIN CLINIC
7. BACK(NECK) SURGERY
8. BRACE

PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

1. DIABETES
2. RHEUMATOID ARTHRITIS
3. CANCER
4. STEROID MEDICATION (PREDNISONE)
5. BLEEDING DISORDER
6. BLOOD CLOTS (DVT, PE)

- 7. HEART DISEASE
- 8. DIFFICULTY SWALLOWING

SOCIAL

DO YOU SMOKE? YES NO

WORK HISTORY

OCCUPATION _____
 DATE LAST WORKED _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS?

TEST	YES	NO	DATE	PLACE
BACK X-RAY	_____	_____	_____	_____
NECK X-RAY	_____	_____	_____	_____
CAT SCAN OF SPINE	_____	_____	_____	_____
MRI SCAN OF SPINE	_____	_____	_____	_____
MYELOGRAM	_____	_____	_____	_____
BONE SCAN	_____	_____	_____	_____
EMG	_____	_____	_____	_____

HAVE YOU EVER HAD PREVIOUS BACK SURGERY?

	DATE	SURGERY	HOSPITAL	SURGEON
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____