

Neck/Back (1)

Was this an injury or did it occur over time? _____

Date of injury or How long you have had this problem: _____

If an injury, describe how it occurred: _____

Were you seen in the emergency room? Yes / No Where? _____

If an auto accident, circle all that describe you in the accident: driver / passenger / front seat / back seat / seat belt

Have you had this or a similar problem before? Yes / No

If so, what problem and how was it treated? _____

When did your pain start? Immediately / Later: _____

Describe your pain (circle all that apply)

Sharp Aching Stabbing Dull

Burning Pins & Needles Throbbing

Constant Intermittent Chronic

Getting better Worse Unchanged

Worse in morning Worse in evening
 Worse at night

Medications used for this problem: _____

My pain combination:

100%Neck/Back 0%Arm/Leg

75%Neck/Back 25%Arm/Leg

50%Neck/Back 50%Arm/Leg

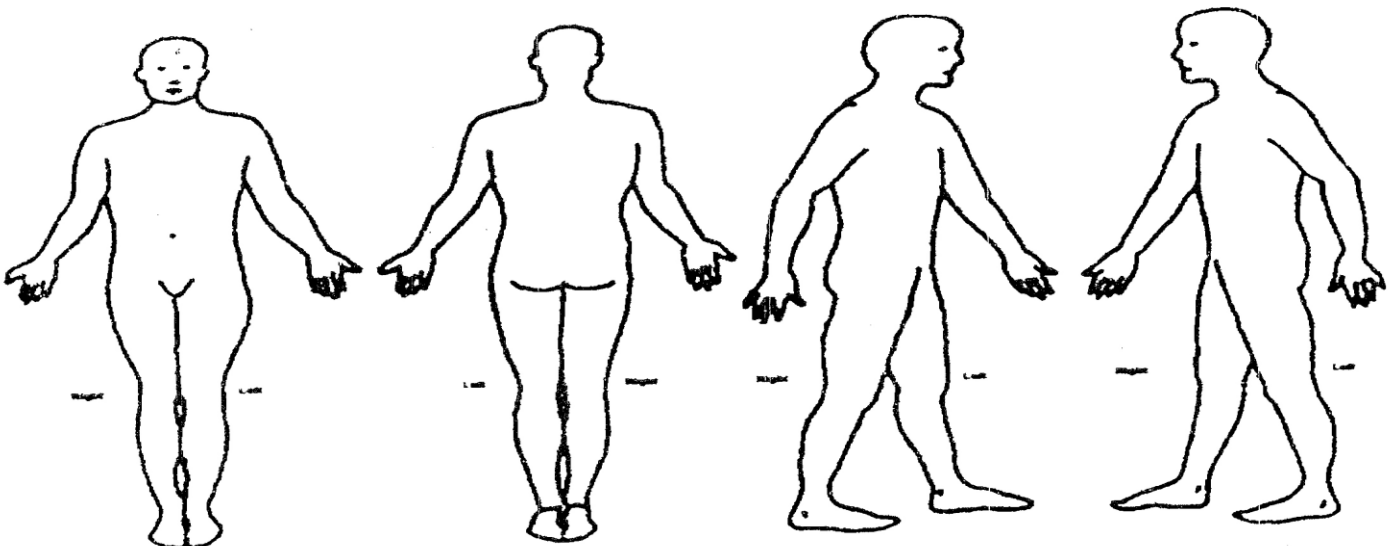
25%Neck/Back 75%Arm/Leg

0%Neck/Back 100%Arm/Leg

Have you had any tests for this problem: MRI / Bone Scan / X-Ray / Other: _____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Please indicate the location(s) of your pain with an X:



Name _____

Date: _____

Does the pain wake you at night? Yes / No

Does the pain radiate from one place to another? Yes / No Where? _____

Do you have numbness or tingling? Yes / No Where? _____

Do you have swelling? Yes / No Where? _____

Do you have any weakness? Yes / No Where? _____

Do you have any bladder problems? No / Exertional incontinence / Leakage / Infection

Do you have any bowel problems? No / Constipation / Incontinence / Diarrhea

Does your problem cause sexual dysfunction? Yes / No

How long can you walk until you experience pain? _____ minutes

Have you had any surgery on your neck or back? Yes / No

Please list dates, doctors, and operations:

Did any symptoms remain after the surgery? Yes / No

Please describe:

Do you have any other problems not previously described? Yes / No

Please list:

Please mark how the following activities affect your pain:

	Worse	No effect	Better
Climbing			
Sitting			
Getting up from a chair			
Riding in the car			
Bending forward			
Coughing/Sneezing			
Straining with bowels			
Standing			
Walking			
Running			
Throwing			
Going up stairs			
Going down stairs			
Lying on back			
Lying on right / left side			
Lifting			
Pushing / Pulling			

Name _____

Date: _____

Neck/Back (3)

If you have used any of the following, please indicate the results:

	Not Used	No Help	Helped	Helped a lot	Still use
Physical Therapy					
Exercise					
Chiropractic					
Weight Lifting					
Aquatics					
Acupuncture					
Ice					
Heat					
Braces					
Steroid Injection					
Walking					
Other					

Referring Physician: _____

Other Physician you have seen for this problem: _____

Dates of work/school missed for this problem: _____

Is there an attorney involved with this problem? If yes, please provide additional information.

Patient Name: _____

Patient Signature: _____

Date: _____