## BACK HISTORY

Name:_____

First time back pain or leg pain occurred?_____

Did pain start gradual?_____ Rapid?_____

Did pain result from an accident? Yes_____ No_____

Is there radiation of pain into lower extremities? Yes_____ No_____

If yes, which side? Right_____ Left_____

Does coughing or sneezing make the pain worse? Yes_____ No_____

Any numbness or tingling in the lower extremities? Yes_____ No_____

Any trouble with accidental urination? Yes_____ No_____

Do you have night pain? Yes_____ No_____

Any previous back surgery? Yes____ No____ If yes, Date:_____

Have you had physical therapy for this problem? Yes_____ No_____

If yes, where?_____How long?_____

When did the most recent episode of back pain start?_____

Has another doctor treated you for this problem? Yes_____ No_____

If yes, who?_____when?_____

Have you taken any medication for this problem? Yes_____ No_____

If yes, what medicine?_____How much?_____

Have you ever had a Work Comp injury? Yes_____ No_____

If yes, please explain:_____

_____

_____

_____

If this pain or injury was resulting from an accident, please describe the accident and date it occurred._____

_____

_____

## NECK HISTORY

Name:_____

Did pain start gradual?_____ Rapid?_____ Date pain started:_____

Did pain result from an accident? Yes_____ No_____

Is there any radiation of pain to the upper extremities? Yes____ No____

If yes, what side? Right_____ Left_____ Both_____

Any numbness or tingling to arms or hands? Yes_____ No_____

Any weakness to arms or hands? Yes_____ No_____

Do you have night pain? Yes_____ No_____

Any previous neck injury? Yes___ No___ If yes, Date:_____

Any previous neck surgery? Yes____ No____ If yes, Date:_____

If this pain or injury is resulting from an accident, please describe the accident and the date it occurred._____

_____

_____

Have you had physical therapy for this problem? Yes_____ No_____

If yes, where?_____How long?_____

Has another doctor treated you for this problem? Yes_____ No_____

If yes, who?_____When?_____

Have you taken any medication for this problem? Yes_____ No_____

If yes, what medicine?_____How much?_____

Have you ever had a Work Comp injury? Yes_____ No_____

If yes, please explain:_____

_____

_____

**IMPORTANT!!!**

PLEASE COMPLETE THE QUESTIONS AND DIAGRAM ON THE BACK OF THIS SHEET.

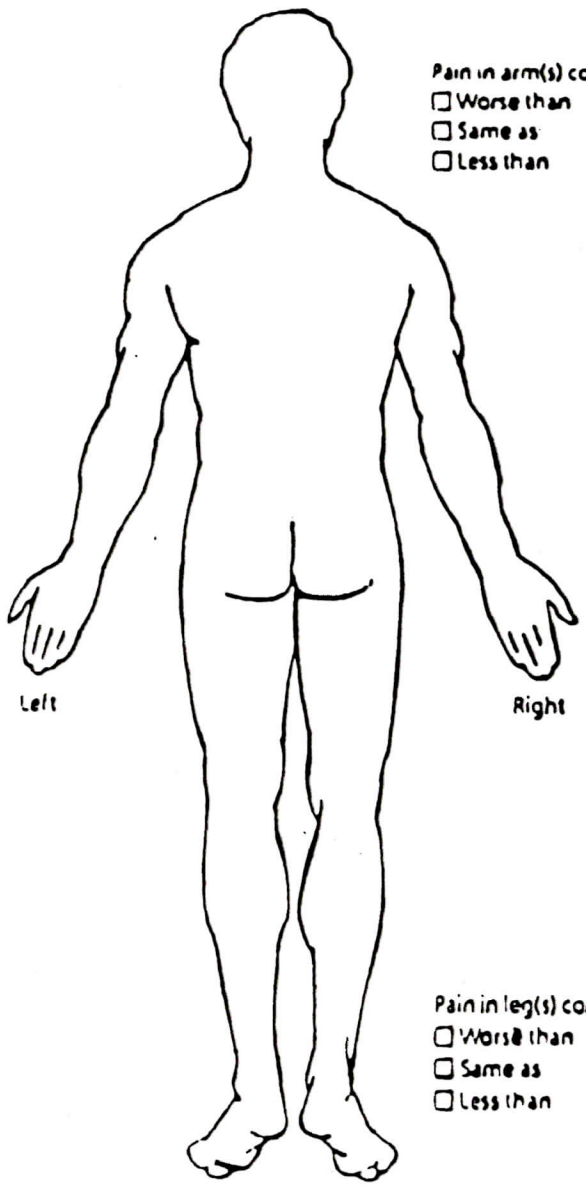
## PATIENT PAIN DRAWING

Name: _____ Date: _____

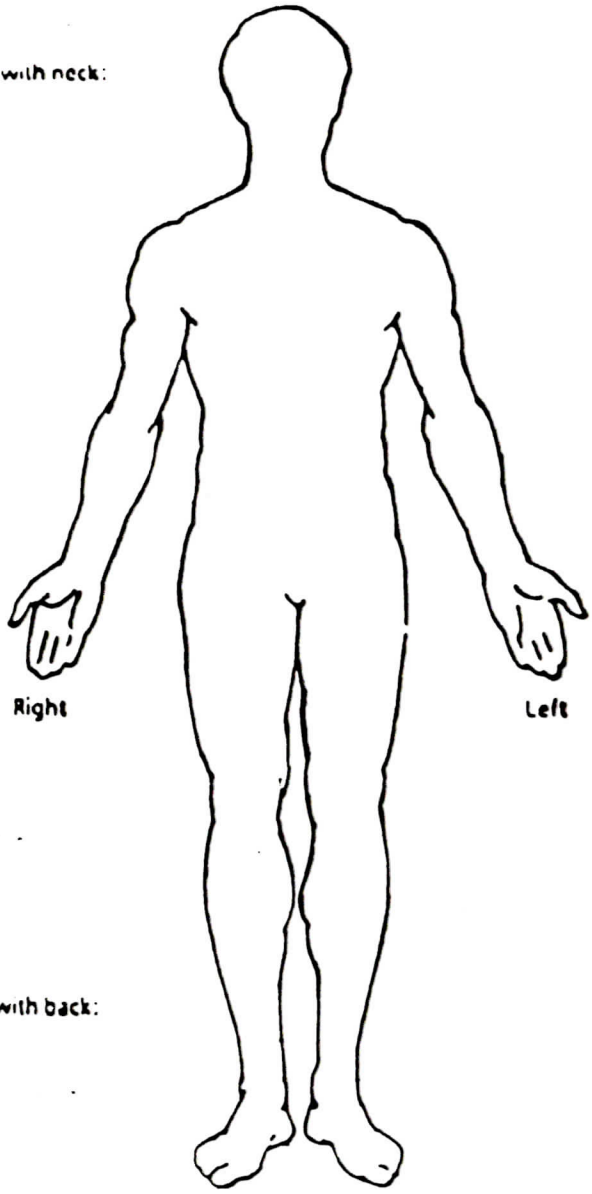
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

| Aching | Numbness | Pins and needles | Burning | Stabbing | Other |
|---|---|---|---|---|---|
| ▲ ▲ ▲ | = = = | O O O | x x x | /// | • • • |

Back




Front




Pain in arm(s) compared with neck:
- ☐ Worse than
- ☐ Same as
- ☐ Less than

Pain in leg(s) compared with back:
- ☐ Worse than
- ☐ Same as
- ☐ Less than