NECK / BACK

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

How long have you had this problem or what was the date of your injury?_____

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 yes, 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	Getting worse
Unchanged	Worse in the morning	Worse in the evening	Worse at night

My Pain Combination:

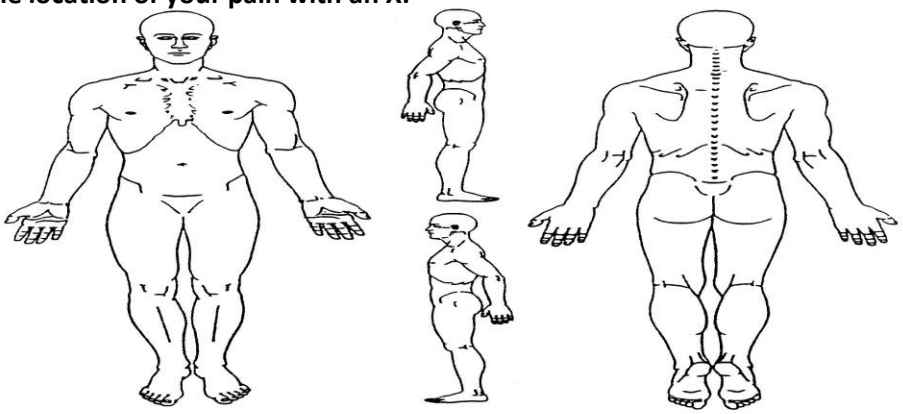
100% Neck / Back	0% Arm / Leg	25% Neck / Back	75% Arm / Leg
75% Neck / Back	25% Arm / Leg	0% Neck / Back	100% Arm / Leg
50% Neck / Back	50% Arm / Leg		

Medications used for this problem:_____

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 Absolute Pain

Please indicate the location of your pain with an X:



Does the pain wake you at night? Yes / No

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

Do you have numbness or tingling? Yes / No If yes, where?_____

Do you have swelling? Yes / No If yes, where?_____

Do you have any weakness? Yes / No If yes, 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

NECK / BACK

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 If yes, please describe:_____

_____

Please mark how the following activities affect your pain:

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

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(s) you have seen for this problem:_____

Date(s) of work/school missed for this problem:_____

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information:_____

_____

Patient Name *(please print)*:_____

Patient Signature:_____ Date:_____