

# Spine Evaluation

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for visit:  Neck  Upper Back  Mid Back  Lower Back Other: \_\_\_\_\_

Side:  Left  Right  Both Hand Dominance:  Left  Right Date of injury/Symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this problem related to an injury?  Yes  No Motor vehicle accident?  work related injury?  sports related injury?

Describe how the injury occurred: \_\_\_\_\_

Have you had surgery on this body part? \_\_\_\_\_ If yes, Procedure and Date: \_\_\_\_\_

Onset:  Sudden  Gradual Duration: How long have you had this problem: # \_\_\_\_\_  Hours  Days  Weeks  Months  Years

Pattern:  Constant  Intermittent  Persistent Course:  Improving  Worsening  Recurrent  Without Change

Radiation of Pain:  None  Neck  Upper Extremity  Lower Extremity  Groin  Buttocks  Thigh

<b>Location:</b>	<b>Severity of Pain:</b>	<b>Characterized As:</b>	<b>Associated Features:</b>
<input type="checkbox"/> Upper Back	<input type="checkbox"/> None	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull	<input type="checkbox"/> Catching <input type="checkbox"/> Balance Difficulties
<input type="checkbox"/> Mid Back	<input type="checkbox"/> Mild	<input type="checkbox"/> Aching <input type="checkbox"/> Throbbing	<input type="checkbox"/> Stiffness <input type="checkbox"/> Gait Abnormality
<input type="checkbox"/> Lower Back	<input type="checkbox"/> Mild to Moderate	<input type="checkbox"/> Cramping <input type="checkbox"/> Stabbing	<input type="checkbox"/> Hip Pain <input type="checkbox"/> Unusual Sensation
<input type="checkbox"/> Neck	<input type="checkbox"/> Moderate	<input type="checkbox"/> Night Pain <input type="checkbox"/> Burning	<input type="checkbox"/> Grinding <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Shoulder Blades	<input type="checkbox"/> Moderate to Severe	<input type="checkbox"/> Numbness <input type="checkbox"/> Shooting	<input type="checkbox"/> Instability <input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Hip <input type="checkbox"/> Thigh	<input type="checkbox"/> Severe	<input type="checkbox"/> Tightness <input type="checkbox"/> Piercing	<input type="checkbox"/> Weakness <input type="checkbox"/> Incontinence

<b>Aggravated by:</b>	<b>Relieved by:</b>	<b>Physical Therapy For this injury?</b>	<b>Use of Assisted devices:</b>
<input type="checkbox"/> Nothing <input type="checkbox"/> Rest	<input type="checkbox"/> Nothing <input type="checkbox"/> Massage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None <input type="checkbox"/> Bracing
<input type="checkbox"/> Walking <input type="checkbox"/> Prolonged Standing	<input type="checkbox"/> Rest <input type="checkbox"/> Modified Activity	<input type="checkbox"/> Epidual Injection	<input type="checkbox"/> Cane <input type="checkbox"/> Crutches
<input type="checkbox"/> Pulling <input type="checkbox"/> Physical Activities	<input type="checkbox"/> Lying Down <input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair
<input type="checkbox"/> Bending <input type="checkbox"/> Sports Activities	<input type="checkbox"/> Ice <input type="checkbox"/> Medication		
<input type="checkbox"/> Lifting <input type="checkbox"/> Work Activities	<input type="checkbox"/> Heat <input type="checkbox"/> Bracing		
<input type="checkbox"/> Throwing <input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Exercise <input type="checkbox"/> Cortisone Injections		

Previous Diagnostic Tests:  X-ray  MRI  CT Scan  Arthrogram  Bonescan  EMG/NCS

\*Where was it taken?: \_\_\_\_\_

## Review of Symptoms

Please check all that apply

<b>General:</b> <input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue  <b>Skin:</b> <input type="checkbox"/> Bruising <input type="checkbox"/> Rash  <b>Respiratory:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	<b>Cardiovascular:</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg Swelling  <b>Gastrointestinal:</b> <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea  <b>Psychiatric:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia	<b>Musculoskeletal:</b> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Leg Cramps  <b>Hematology:</b> <input type="checkbox"/> Calf Pain <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	<b>Neurological:</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches  <b>Geniurinary:</b> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Difficulty Urinating
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Patient Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_