

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: ____/____/____

Have you had surgery on this body part? _____ If Yes, Procedure and Date _____

Is this a work related injury? Yes No Explain: _____

Is this a result of a motor vehicle accident? Yes No Explain: _____

Is this a sports related injury? Yes No Explain: _____

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

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

Aggravated by:	Relieved by:	Have you had prior Physical Therapy:	Use of Assisted devices:
<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Walking <input type="checkbox"/> Prolonged Standing <input type="checkbox"/> Pulling <input type="checkbox"/> Physical Activities <input type="checkbox"/> Bending <input type="checkbox"/> Sports Activities <input type="checkbox"/> Lifting <input type="checkbox"/> Work Activities <input type="checkbox"/> Throwing <input type="checkbox"/> Climbing Stairs	<input type="checkbox"/> Nothing <input type="checkbox"/> Massage <input type="checkbox"/> Rest <input type="checkbox"/> Modified Activity <input type="checkbox"/> Lying Down <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Ice <input type="checkbox"/> Medication <input type="checkbox"/> Heat <input type="checkbox"/> Bracing <input type="checkbox"/> Exercise <input type="checkbox"/> Cortisone Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No When? _____ Where? _____	<input type="checkbox"/> None <input type="checkbox"/> Bracing <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair

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

*Where was it taken?: _____

Review of Symptoms

Please check all that apply

General:	Cardiovascular:	Musculoskeletal:	Neurological:
<input type="checkbox"/> Feeling Well <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue Skin: <input type="checkbox"/> Bruising <input type="checkbox"/> Rash Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Edema <input type="checkbox"/> Phlebitis Gastrointestinal: <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Constipation Psychiatric: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Dementia	<input type="checkbox"/> Calf Pain <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 Hematology: <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Nose Bleeds	<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 Genitourinary: <input type="checkbox"/> Recurrent Urinary Infection <input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Prostate Cancer

Patient Signature: _____ Date ____/____/____

Physician Signature: _____ Date ____/____/____