Name:

DOB:

OrthoCincy

Date:

Spine Evaluation

Referring Physician: _____ Primary Care Physician: _____

Name a favorite hobby: _____

Where is the pain in your back: ☐ Neck ☐ Upper back ☐ Lower back

Describe how it happened _____

Describe where you were: _____

Did your pain come on: ☐ Suddenly ☐ Gradually ☐ Fall ☐ Bending ☐ Pulling ☐ Lifting ☐ Hit from behind ☐ No apparent cause

The date the symptoms began: _____

When is your pain worse? ☐ Mornings ☐ Evenings ☐ Always about the same

What makes the pain worse: ☐ During exercise ☐ After exercise ☐ Sitting ☐ Standing ☐ Walking ☐ Coughing ☐ Bending forward ☐ Bending Backward ☐ Sneezing ☐ Other: _____

What reduces the pain: ☐ Laying down ☐ Sitting ☐ Standing ☐ Walking ☐ Manipulation ☐ Exercise (physical therapy) ☐ Medication ☐ Injections ☐ Tens Unit ☐ Brace/Corset ☐ Nothing ☐ Other: _____

On this diagram mark where you have the following sensations:

ΔΔΔ Aching

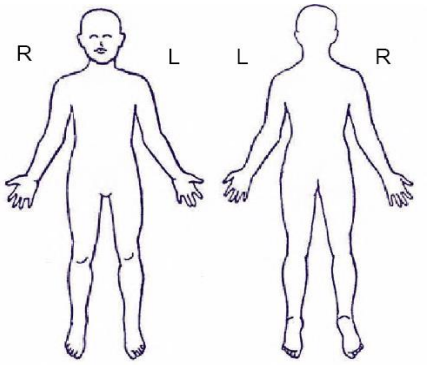
=== Numbness

ooo Tingling

+++ Pins and Needles

XXX Burning

/ / / Stabbing



For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT IMPROVING WORSENING VARYING IN INTENSITY

What is your pain scale today: 0=no pain 10=worst pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	BACK PAIN	LEG PAIN
	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
	NECK PAIN	ARM PAIN

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐ yes ☐ no
If so, please provide details: _____

Have you seen any other doctors for your CURRENT problem? ☐ yes ☐ no If yes, who and when: _____

Are you currently being treated by pain management? ☐ yes ☐ no If yes, who? _____

Are you experiencing any problems with bowel or bladder control? ☐ yes ☐ no If yes, explain: _____

My weight is: ☐ increasing ☐ decreasing ☐ steady

Are there any problems with weak muscles? ☐ **NONE** ☐ Generally weak ☐ Weak in arms ☐ Weak in legs

I can comfortably: Stand for ____ minutes Sit for ____ minutes Walk for ____ minutes

Name:

DOB:

OrthoCincy

Date:

Place an X in the appropriate box:

I can do the following:	All	Some	None
Housework			
Leisure Activity			
Work			

Previous treatment for this problem: ☐ **NONE**

Treatment	Date	Provider's name	Other info
Physical Therapy/Exercise			What was done? Number of sessions
Tens Unit			Do you use it?
Epidural Steroid Injection (Shot into the back)	1st		Helpful? How long?
Epidural Steroid Injection (Shot into the back)	2nd		Helpful? How long?
Epidural Steroid Injection (Shot into the back)	3rd		Helpful? How long?
Acupuncture/Massage Therapy/ Chiropractic Manipulation			Helpful?
Pain Specialist			

Previous tests for this problem: ☐ **NONE**

Test	Date	Where	Results (if known)
X-rays			
Myelogram			
EMG			
CT scan			
Bone scan			
MRI			
MRI 2nd if applicable			
Discogram			

Any previous CARDIAC procedures including cardiac stress test and EKG: ☐ **NONE**

Date	Surgeon/Facility	Procedure/Test

Any previous NECK or BACK surgeries? ☐ **NONE**

Date	Surgeon	Helpful?	What was done?
		Yes / No	
		Yes / No	
		Yes / No	
		Yes / No	

Possible contraindications for back surgery:

Do you have breast implants? ☐ yes ☐ no

Are you diagnosed with glaucoma? ☐ yes ☐ no

Patient Signature: _____

BC16