

Comprehensive Spine Assessment

Name: _____

Referring Physician: _____

Age _____

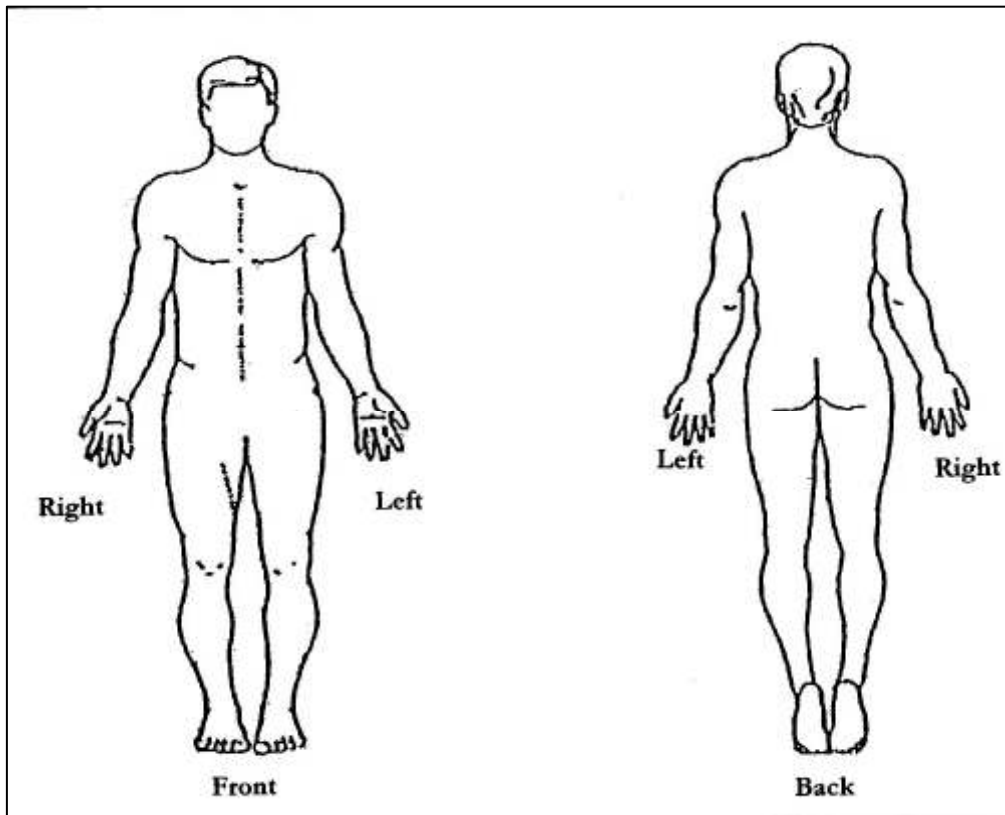
Sex: Male Female

Primary Physician: _____

Pain diagram:

Indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and please indicate where the pain is the worst.

- Aching/pain (xxxx)
- Numbness/Tingling (oooo)
- Pins/needles (----)
- Burning (/////)
- Spasm/cramp (#####)



Rate your pain at its best < 1 3 5 7 10 > Rate your pain at its worst < 1 3 5 7 10 >

Where do you have pain? _____

When did your pain start? _____

Was there an injury that led to the pain? _____

Please describe injury: _____

Symptoms:

Do you have tingling? Yes No
Where? _____

Do you have numbness? Yes No
Where? _____

Treatments:

What treatments have you received for this condition?

When? _____

Physical Therapy _____

Chiropractic _____

Injections _____

What type? _____

MRI _____

CT Scan/Myelo. _____

Hospitalization _____

What other medical/osteopathic/chiropractic physicians have you seen for this problem?

Social History

Do you smoke? If so, how many packs per day?

Do you drink? If so, how much per week?

Are there any medical problems that tend to run in your family? If yes, please list the family member and the medical condition.

Mother _____

Father _____

Brother _____

Sister _____

Please sign below indicating you have completed this form truthfully and as accurately as possible, to the best of your ability.

Signature

Pain Scale:

How much of your pain is in your neck/back and how much is in your arm/leg?

_____ % Neck / Back

_____ % Arm / Leg

What makes your pain worse?

_____ Lying down _____ Looking up/down

_____ Sitting _____ Looking L/R

_____ Standing _____ Bending forward

_____ Walking _____ Bending back

_____ Lifting _____ Sneeze/Cough

_____ Sleeping _____ Twisting

What makes your pain better?

_____ Lying down _____ Looking up/down

_____ Sitting _____ Looking L/R

_____ Standing _____ Bending forward

_____ Walking _____ Bending back

_____ Lifting _____ Sneeze/Cough

_____ Sleeping _____ Twisting

Describe the course of your condition as...

_____ Rapidly worse _____ Rapidly better

_____ Slowly worse _____ Slowly better

_____ Unchanged

Please describe any other emotional stresses in your life currently.

Do you exercise of a regular basis?

_____ No _____ Yes, doing what?

Describe your daily intake of fruits and vegetables?

_____ none _____ 3-5 servings

_____ 0-2 serving _____ 5 + servings per day

Date