OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

Comprehensive Spine Assesment

Name: ________________________________

Age ________ Sex: Male Female

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	(#####)

Symptoms

Where is your pain?

____
____
____
____

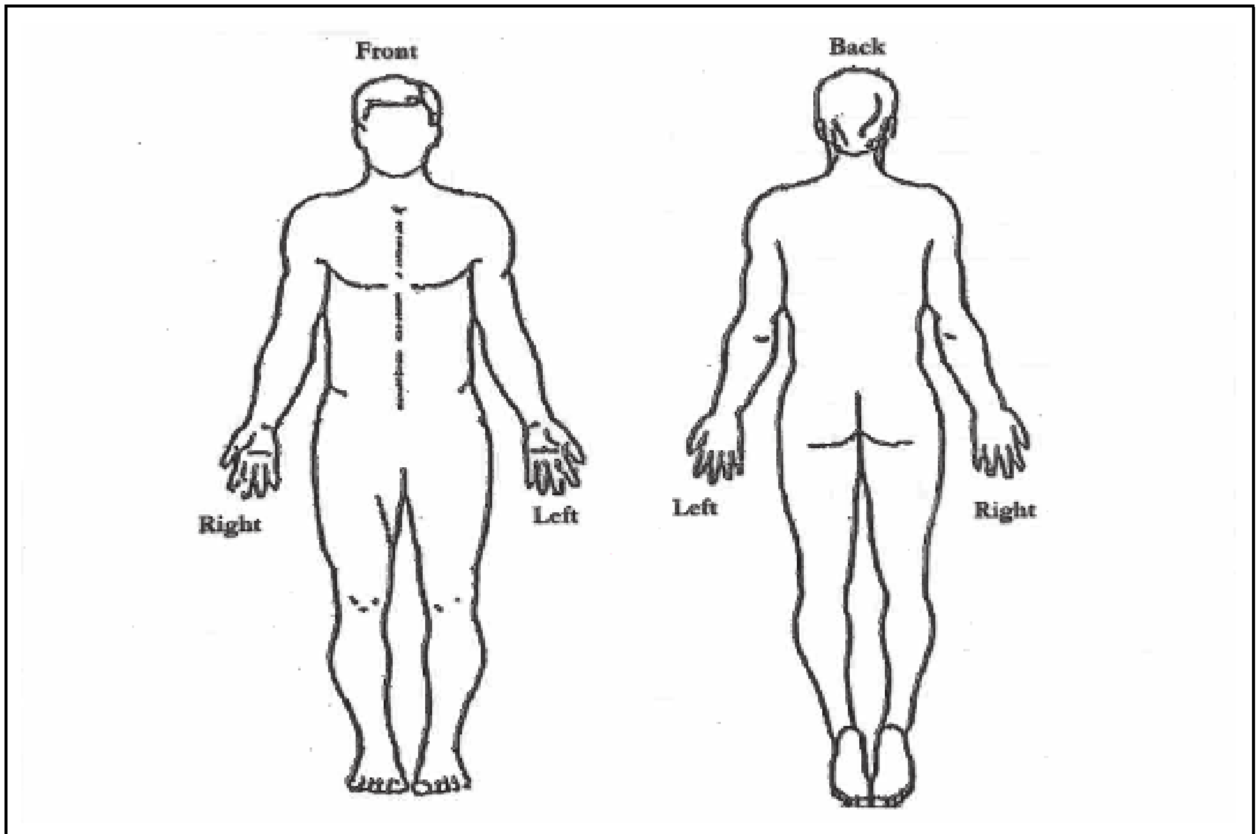
Describe circumstances of the injury.

____
____
____
____

Rate your pain at its worst and its best

0<-----2-----4-----6-----8----->10
best

0<-----2-----4-----6-----8----->10
worst



Work Injury

Employer: ____________________

Length of employment prior to injury: ____________________

Describe circumstances that caused injury ____________________

____

Was your injury witnessed? If so, by whom? ____________________

Do you have an attorney? If so, who? ____________________

Have you filed a work injury claim in the past? ____________________

If so, describe injury and date of injury ____________________

Symptoms

How long have you had these symptoms?

Location	Duration
Head	______
Neck	______
Shoulder L/R	______
Arm L/R	______
Hand L/R	______
Mid back	______
Low back	______
Hip L/R	______
Buttock	______
Leg L/R	______

Since pain started, have you noticed any of the following symptoms? (circle all that apply)

Numbness/weakness in arm	LT	RT
Numbness/weakness in hand	LT	RT
Numbness/weakness in leg	LT	RT
Numbness/weakness in foot	LT	RT
Clumsiness of hands	LT	RT
Balance problems		
Bowel/Bladder problems		
Pain that wakes you from sleep		

When having pain, is it generally….

___ mild discomfort or less
___ dull pain, worse at times
___ hard, aching pain, frequently worse
___ severe pain, sharp/shooting at tiimes
___ very severe, sharp, shooting, disabling
___ extremely severe and disabling

How often are you having pain now?

___ Rarely if ever
___ Occasionally (1-2 times per year)
___ Recurrent (2-3 days every month)
___ Frequent (>3 days per month)
___ Very frequent (every week)
___ Everyday

What time of day is your pain usually worse?

___ Morning ___ Same all day
___ Mid-day ___ At night in bed
___ Evening

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

What studies have you had done of your spine?

- __ None
- __ MRI Scan
- __ X-Ray
- __ Bone Scan
- __ CT Scan
- __ EMG/NCV
- __ Myleogram

What treatments have you received?

- __ None
- __ Medication
- __ Manipulation
- __ Traction
- __ Physical Therapy
- __ Spinal Block
- __ Hospitalization
- __ Other ______________________

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

____
____
____

How has pain limited your home/job activities?

- __ Not limited in any way
- __ Not limited much due to pain
- __ Able to work around the pain
- __ Must stop and limit activities
- __ Unable to work for days at a time
- __ Unable to work at all due to pain
- __ Unable to sleep due to pain

How is pain limiting your social/recreational activities?

- __ Not limited in any way
- __ Not limited much due to pain
- __ Able to work around the pain
- __ Must stop and limit activities
- __ Unable to work for days at a time
- __ Unable to work at all due to pain
- __ Unable to sleep due to pain

Have any of the following reasons caused you to be emotionally upset?

- __ Not upset
- __ Work
- __ Marital
- __ Legal
- __ Social
- __ Financial

Do you have any allergies to medications? If so, list the medication and the allergic reaction the medication causes.

____
____
____

Are you allergic to seafood, iodine or contrast?

____
____

What medications do you take currently?

____
____
____
____
____
____
____

Do you have any medical problems for which you regularly see a doctor?

- __ No
- __ Yes, list the doctor and problem

____
____
____
____

Please rate your overall general health.

- __ Excellent
- __ Fair
- __ Good
- __ Poor

What surgeries have you had in the past?

____
____
____
____
____

Social History

What level of education have you completed?

- __ GED
- __ College
- __ High School
- __ Graduate School

Do you exercise on a regular basis?

- __ No
- __ Yes, doing what?

____
____
____

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

____
____

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

____
____

Describe your daily intake of fruits and vegetables?

- __ none
- __ 0-2 serving
- __ 3-5 servings
- __ 5 + servings per day

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

____
____
____
____
____
____
____
____

Activities at home or work mostly involve?

- __ Manual labor/heavy lifting
- __ Manual labor/less strenuous
- __ Sitting most of the day
- __ Walking or standing most of the day
- __ House work and child care

Who is your employer?

____
____

Review of Systems

Please mark all of the following symptoms/conditions that you experience or have experienced

- __ Fevers or chills
- __ Weight loss
- __ Weight gain
- __ Sinus problems
- __ Sore throat
- __ Productive cough
- __ Constipation
- __ Bladder problems
- __ Memory loss
- __ Seizures
- __ Dizziness
- __ Depression/mental illness
- __ Visual problems
- __ Hearing problems
- __ Dental problems
- __ Shortness of breath
- __ Ankle/leg swelling
- __ Chest pain
- __ Urination problems
- __ Rash
- __ Cancer

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

____ Signature

____________________ Date