OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA
(727) 461-6026 www.oawf.com

Comprehensive Spine Assessment

Name: _____

Referring Physician: _____

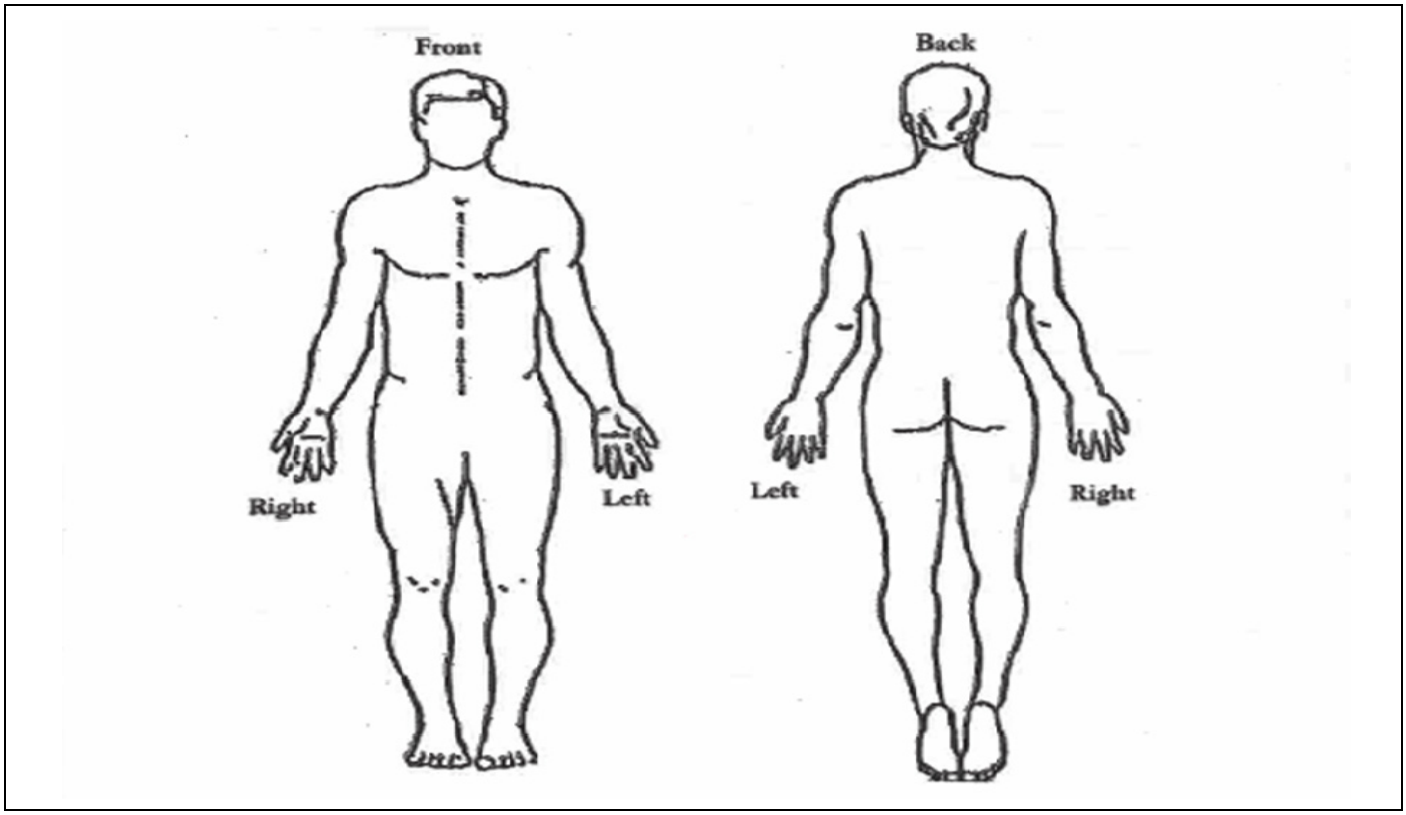
Age _____ Sex: Male ◉ Female ○

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/Myleo. _____

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 _____

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 on 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

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

_____ _____

Signature Date

Submit