



Office Use only:

BP ____ / ____ Pulse ____

Temp ____ Resp ____

Clinician Signature: _____

SPINE HISTORY FORM

Primary Care Doctor: _____

Who referred you here? _____

Name: _____ Date: _____

Age: _____ Birth date: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____

1. Chief Complaint (reason why you are here):

2. History of present problem:

Date problem began: _____

Is this a work-related or auto injury? _____

Did problems begin following? a fall _____ lifting _____ work injury _____

recreational injury _____ automobile accident _____ no apparent cause _____

Where is the pain located? _____

Is the pain better _____ same _____ worse _____ than when it started?

Describe the quality of pain (e.g., burning, stabbing, throbbing) _____

Is the pain? (Circle)

Constant

Constant but worse with activity

Intermittent (comes and goes)

Intermittent, but worse with activity

What makes the pain worse? (e.g., walking, bending, sneezing, coughing, sitting, standing): _____

Is there a time of day when it is worse? Morning _____ Evening _____ Night _____

Does the pain wake you up at night? Yes _____ No _____

Do you have? Fevers/Chills/ or unexplained weight loss? (circle, if applicable) _____

Do you have "pins and needles" in your feet/hands (circle)? _____

Do you have numbness in your feet/hands (circle)? Y N

Do you have weakness in your arms or legs (circle) Y N

Do you have full control of your bowel and bladder? Y N

(explain, if NO): _____

Are you able to perform your usual activities of daily living? Y N

Have you had surgery for this problem? Y N

If so, describe date, surgeon & procedure:

Did surgery help? _____

CHECK ANY STUDIES YOU HAVE HAD FOR CURRENT PROBLEM:

Diagnostic X-rays _____	MRI (magnetic resonance imaging)
CT (computed tomography) _____	Myelogram (x-ray w/spinal inj.)
Discogram _____	Electromyelogram (EMG)
Arthrogram/sonogram _____	

CHECK ANY TREATMENTS YOU HAVE HAD FOR CURRENT PROBLEM:

	<i>How long did you have treatment?</i>
Physical Therapy _____	_____
Home strengthening/stretching _____	_____
Home exercises _____	_____
Acupuncture _____	_____
Chiropractic _____	_____
Epidural spine injections _____	_____
Massage _____	_____
Other (please explain) _____	_____

Have any treatments ever made the pain better? _____ If yes, which treatment helped?
