SPINE HISTORY FORM

(Use back if needed)

FLATHEAD ORTHOPEDICS
flatheadortho.com

Name : _____ **Age:** _____

What are we seeing you for today? _____

1. How long have you had back, neck, leg, or arm pain? _____

2. If you have had pain more than 6 months, has anything changed recently?

_____

3. Please list names of other providers you have seen for this problem: _____

4. How did your problem start? ☐ Gradual onset ☐ Acute injury ☐ Work Injury ☐ Car Accident

☐ Other (please describe): _____

5. On a scale of 0 to 10 (0 = no pain, 10 = worst pain imaginable):

Please rate your ***average*** **BACK/NECK** pain: ____ Please rate your **BACK/NECK** pain ***at its worst*** : ____

Please rate your ***average*** **LEG/ARM** pain: ____ Please rate your **LEG/ARM** pain ***at its worst*** : ____

6. What makes your pain worse? (check all that apply)

☐ Sitting ☐ Standing or walking ☐ Coughing/Sneezing ☐ Other (please describe): _____

7. Of the items in question #6, which one is the worst? (check only one)

☐ Sitting ☐ Standing or walking ☐ Coughing/Sneezing ☐ Other _____

8. What TESTS have you had done on your back?

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Discogram ☐ EMG ☐ Blood Tests

9. What kinds of TREATMENTS have you tried? (Check all that apply, circle which have helped)

☐ Physical Therapy ☐ Chiropractic Treatments ☐ Acupuncture ☐ Massage ☐ TENS Unit

☐ Spine Injections ☐ Surgery ☐ Medications (please list): _____

10. Have you recently had any of the following: (Check all that apply)

☐ Recent fever >100.5F ☐ Night Sweats

☐ Balance Problems / Troubles Walking

☐ Hand Clumsiness

☐ Weakness in your legs?

☐ Numbness in your legs

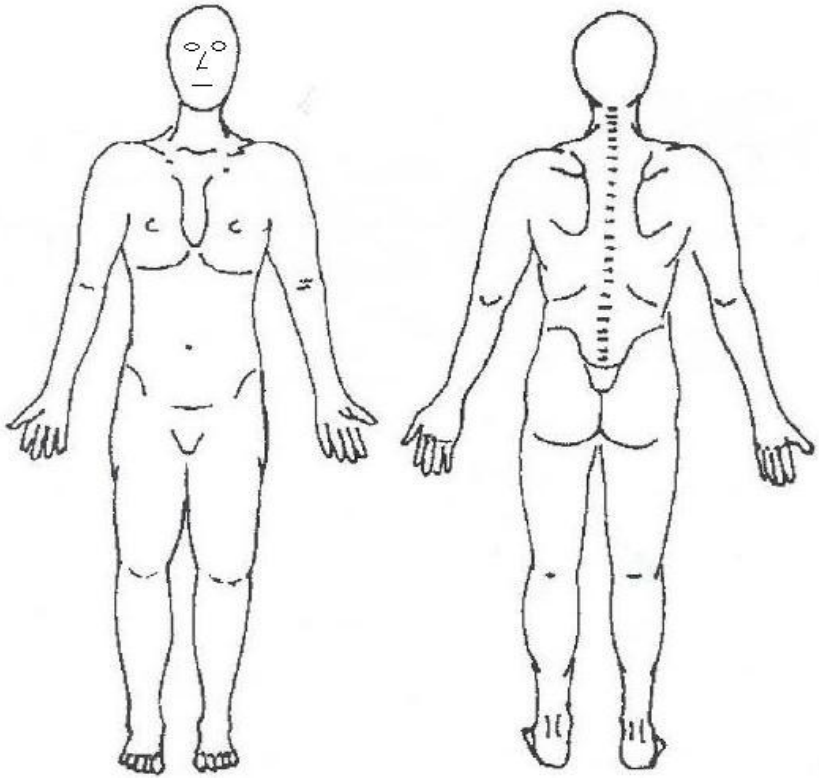
☐ Change in bowel or bladder habits

11. Please draw the type and location of your pain on the figures:

////////////////// Sharp, stabbing pain

XXXXXXX Aching or burning pain

OOOOOOO Numbness (pins / needles)



12. Please sign and date:

_____ _____

Signature Date

Reviewed by: _____ _____

Initials Date