

PAIN DRAWING

PATIENT: _____ AGE: _____ DATE: _____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE	^^^	NUMBNESS	ooo	PINS & NEEDLES	■ ■ ■	BURNING	X X X	RADIATING PAIN	///
	^^^		ooo		■ ■ ■		X X X		///
	^^^		ooo		■ ■ ■		X X X		///

Neck Pain	_____	%
Arm Pain	_____	%
Back Pain	_____	%
Leg Pain	_____	%
Total = 100%		

PLEASE MARK ON THE LINE:

How bad is your pain now?



Is your problem related to:

- Job Injury
- Car Accident

Is there any litigation pending?

- No
- Yes

Please describe car accident or job injury: _____

Please describe your main problem:

How has this interfered with your life?

How long has this been a problem? _____

My pain is best when Walking Standing Sitting Laying down

My pain is worst when Walking Standing Sitting Laying down

What else makes the pain better? _____

What else makes the pain worse? _____

How does coughing or sneezing affect the pain? Worse Better No difference

How long can you stand with no or minimal pain? _____

How far can you walk with no or minimal pain? _____

Have you ever had any problems like this in the past or required hospitalization for this?

Have you seen any other doctors for this problem or had previous back/neck surgery?

Dr. _____ Specialty _____ Date _____ Recommendation: _____

Dr. _____ Specialty _____ Date _____ Recommendation: _____

Describe your treatment(s) to date (including injections, chiropractor/alternative treatments)

Which diagnostic tests were performed?

Xrays Date _____ Results _____

CT scan Date _____ Results _____

MRI Date _____ Results _____

EMG Date _____ Results _____

Discogram Date _____ Results _____

Myelogram Date _____ Results _____

DEXA Scan Date _____ Results _____

For office use only:

MEDICAL HISTORY

Please check below any condition that applies and add any comments that apply.

	YES	NO	Comments		YES	NO	Comments
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Bleeding Disorder				Immune Disorder			
Bowel Disorder				Kidney Disorder			
Cancer				Liver Disease			
Depression				Rheumatoid Arthritis			
Diabetes				Stroke			
Drug/Alcohol Abuse				Thyroid Disease			
Epilepsy				Tuberculosis			
Heart Disease				Ulcers			
Other (describe):							

Previous Hospitalizations, major surgeries, serious infections and approximate dates

SOCIAL HISTORY

Occupation _____ Marital Status _____ Highest education level _____

Work Status: Full Duty Light Duty Off Duty (per M.D.) Unemployed Retired

If you are not working full duty, how long have you been off work? _____

Tobacco YES NO

Cigarettes Pack(s) per day _____ How many years ____ If you quit, when? _____

Other tobacco Amount per day _____ How many years ____ If you quit, when? _____

Alcohol YES NO

If yes, how often and how much _____

Have you ever received formal treatment for dependency _____

Do you currently or have you ever used any recreational drugs? YES NO

If yes, please list all and how often _____

FAMILY HISTORY

Please list health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

SYSTEM REVIEW Please answer yes or no with a check mark or X.

Constitutional			GenitoUrinary		
Recent weight changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bloody urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recurrent fevers/chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Burning with urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eyes, Ear, Nose, Throat			Unable to control bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unable to control bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal periods (women)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological		
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness/tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Respiratory			Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breathing problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crying problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma or wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin		
Cardiovascular			Rashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Non-healing wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty exercising	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Easy bruising/bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling of feet/hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Musculoskeletal		
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint pain/swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal			Muscle pain/cramping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endocrine		
Bleeding ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Excess thirst/urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bloody stools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic		
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent cold/flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay/dust fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

I have personally reviewed and discussed all the preceding information with my patients.

Physician Signature _____

Date _____

MEDICATIONS FORM

List all medications – please include dosages and frequency

Medications	Dosage	Medications	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU CURRENTLY ON ANY TYPE OF BLOOD THINNER: Yes No

Medication	3	Helpful?	Medication	3	Helpful?	Medication	3	Helpful?
Aspirin			Glucosamine			Prozac		
Bextra			Ibuprofen			Relafen		
Celebrex			Lortab			Skelaxin		
Darvocet			Mobic			Soma		
Demerol			Motrin			Tylenol		
Dilaudid			Naprosyn			Tylenol #3		
Duragesic			Oxycodone			Valium		
Elavil			Oxycontin			Vicodin		
Flexeril			Predisone			Vioxx		

Allergies

Please list all medications you have allergies to and the type of reaction

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

I have personally reviewed and discussed the medication and allergy information with my patient.

Provider Signature _____ Date _____

BACK PAIN DISABILITY INDEX

(Oswestry 2.0)

This questionnaire is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section apply to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2 – Personal care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4 – Walking

- Pain does not prevent me walking any distance
- Pain prevents me walking more than 1 mile
- Pain prevents me walking more than ¼ of a mile
- Pain prevents me walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour

- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7 – Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain, I have less than 6 hours of sleep
- Because of pain, I have less than 4 hours of sleep
- Because of pain, I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

Section 8 – Sex Life

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 – Social life

- My social life is normal and causes me no extra pain
- My social life is normal, but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10 – Travel

- I can travel anywhere without pain
- I can travel anywhere but it gives extra pain
- Pain is bad but I manage journeys over 2 hours
- Pain restricts me to journeys less than 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me traveling except to receive treatment

Please describe how you have felt during the PAST WEEK by marking a check mark (✓) in the appropriate box. Please answer all questions. Do not think too long before answering.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
Heart rate increase				
Sweating all over				
Sweating in a particular part of the body				
Pulse in neck				
Pounding in head				
Dizziness				
Blurring of vision				
Feeling faint				
Everything appearing unreal				
Nausea				
Butterflies in stomach				
Pain or ache in stomach				
Stomach churning				
Desire to pass water (urinate)				
Mouth becoming dry				
Difficulty swallowing				
Muscles in neck aching				
Legs feeling weak				
Muscles twitching or jumping				
Tense feeling across forehead				
Tense feeling in jaw muscles				

Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
I feel downhearted and sad				
Morning is when I feel best				
I have crying spells or feel like it				
I have trouble getting to sleep at night				
I feel that nobody cares				
I eat as much as I used to				
I still enjoy sex				
I notice I am losing weight				
I have trouble with constipation				
My heart beats faster than usual				
I get tired for no reason				
My mind is as clear as it used to be				
I tend to wake up too early				
I find it easy to do the things I used to				
I am restless and can't keep still				
I feel hopeful about the future				
I am more irritable than usual				
I find it easy to make a decision				
I feel quite guilty				
I feel that I am useful and needed				
My life is pretty full				
I feel that others would be better off if I were dead				
I am still able to enjoy the things I used to				

PHYSICAL EXAMINATION

Patient _____ **DOB** _____ **Date of exam** _____

Height _____ **BP** _____ **Oswestry** _____
Weight _____ **HR** _____ **MSPQ** _____
Zung _____

General

Appearance Pleasant, groomed Disheveled Depressed
 Affect Alert Oriented Confused

Scoliosis _____ Thoracic _____ TL/Lumbar
 _____ Shoulder elevated _____ Plumb Line
 _____ Waist elevated _____ Adam's Forward Bending

Gait Trendelenburg Antalgic Wheelchair Bound

ROM

	Flexion	Extension	Lat Rotation	Lat Flexion
Cervical				
Lumbar				

Motor Exam

Cervical						Lumbar					
		Motor		Sensation				Motor		Sensation	
	Level	L	R	L	R		Level	L	R	L	R
Deltoid	C5					Iliopsoas	L2				
Biceps	C6					Quad	L3				
Wr Ext	C6					TA	L4				
Triceps	C7					EHL	L5				
Wr Flex	C7					Peroneals	L5				
Fin Ext	C7					GS	S1				
Fin Flex	C8										
IO	T1										

Reflexes

	Right	Left		Right	Left
Biceps	_____	_____	Patella	_____	_____
Brachioradialis	_____	_____	Achilles	_____	_____
Triceps	_____	_____			

Pathologic Reflexes

Babinski No Yes
 Clonus No Beats _____
 Abdominal No Yes
 Hoffman's No Yes
 Finger Escape No Yes
 Jaw Jerk No Yes

Cranial/Brainstem Exam

Dysdiadokinesis No Yes
 Heel/shin No Yes

Cauda Equina

Rectal tone Yes No

Musculoskeletal Exam

Shoulder Right Left

Impingement

RTC

Dislocation

Other

Hip Right Left

Arthritis

Other

Knee Right Left

Arthritis

Meniscus

Other

Systems Exam

Head and Neck

Normocephalic

Lymph nodes normal

CV

RRR

No murmurs, rhythm abnormalities

Lungs

CTAB

Abdominal

Soft, NT/ND, BS present

Radiology

Xrays

MRI

CT/Myelogram

Lab Tests

Impression

Plan