

Comprehensive Spine Assessment

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.

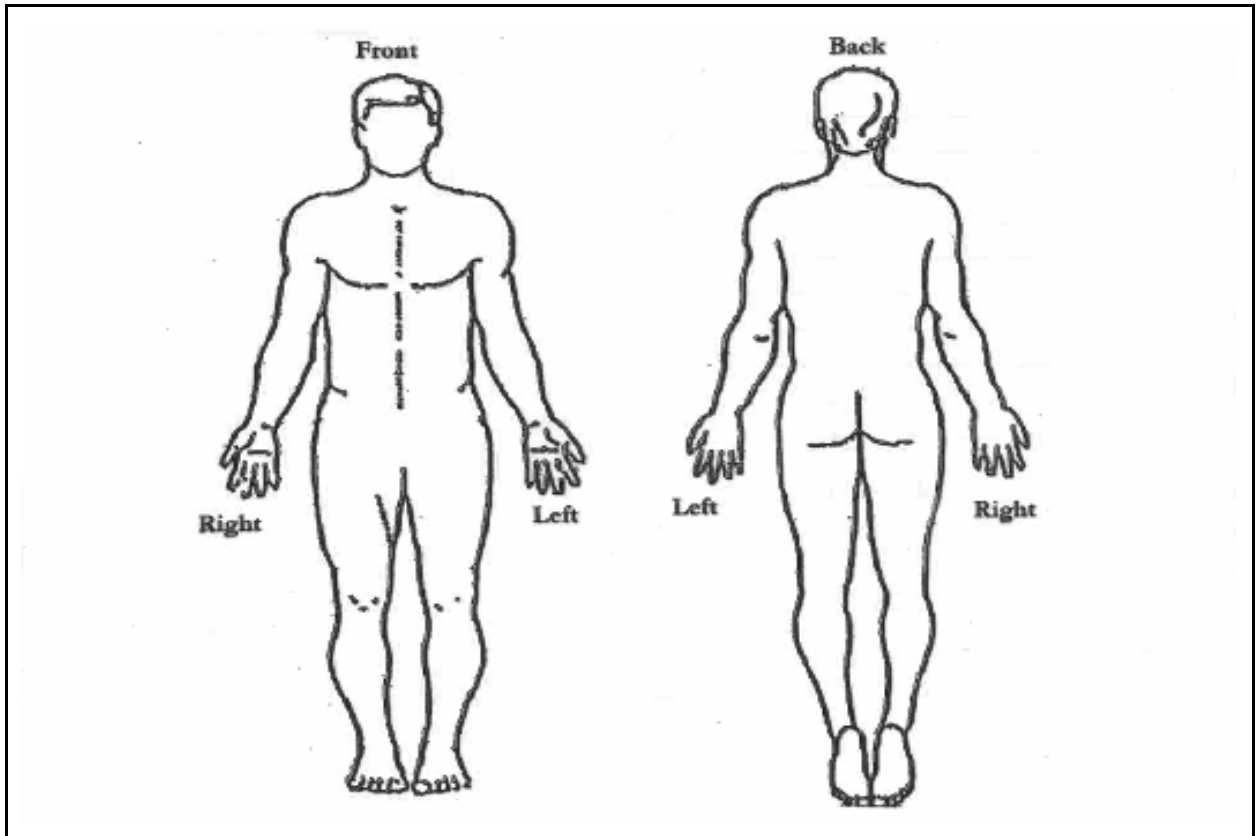
Rate your pain at its worst and its best

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?

<u>Location</u>	<u>Duration</u>
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 times
- ___ 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
 - Slowly worse
 - Unchanged
 - Rapidly better
 - Slowly better

- What studies have you had done of your spine?
- None
 - X-Ray
 - CT Scan
 - Myelogram
 - MRI Scan
 - Bone Scan
 - EMG/NCV

- What treatments have you received?
- None
 - Medication
 - Manipulation
 - Traction
 - Physical Therapy
 - Spinal Block
 - Hospitalization
 - Other _____

What other medical/osteopathic/chiropractic physicians have you 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
 - Marital
 - Social
 - Work
 - Legal
 - 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
- Good
- Fair
- 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