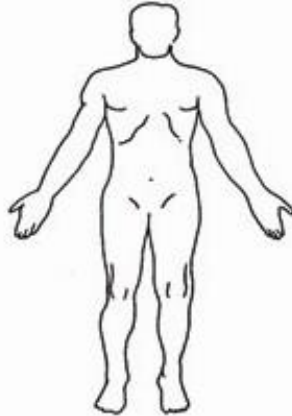
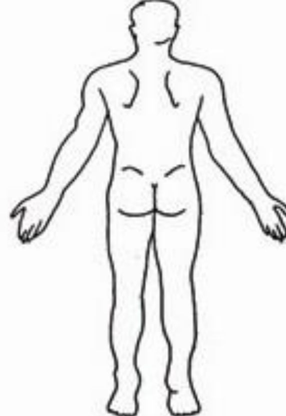
MIDLANDS
orthopaedics
&NEUROSURGERY

Patient Name: ______________________________
Date of Birth: ______________ **Appt Date** __________
Chart Number: ______________________________

PAIN LOCATION (Please mark the location(s) of your pain on the diagrams below)



Front



Back

Circle your average level of pain in your back and/or neck:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Circle your average level of pain in your leg and/or arm:
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How did your pain start? Check all that apply to you.
__ Suddenly Lifting____Bending____Fall____Gradually____Twisting____Pulling____Accident____No apparent

Please indicate which activities below increase, decrease or cause no change in the level of your pain.

	Lying	Standing	Bending Forward	Bending Backward	Twisting	Sitting	Walking	Coughing Sneezing	Exercise (during)	Exercise (after)
Increases Pain										
Reduces pain										
No change										

Please check the approximate amount of time you can perform the following activities.

	unable	15 minutes	30 minutes	45 minutes	1 hour	indefinitely
Sit						
Stand						
Walk						

What treatments have you tried for this current pain?

___Physical Therapy ___Chiropractic _Acupuncture ___Home Exercises ___Surgery ___None

If surgery becomes a treatment option, would you consider it?____yes ___no ___maybe

REVIEW OF SYMPTOMS - Please check ALL items that apply to you.

- ☐ Weight Loss/Gain
- ☐ Fever
- ☐ Arm Numbness
- ☐ Stiffness
- ☐ Severe Nighttime Pain
- ☐ Difficulty Buttoning Buttons
- ☐ Change in Handwriting Ability
- ☐ Other (describe): ____
- ☐ Night Sweats
- ☐ Recent Infections
- ☐ Leg Numbness
- ☐ Swelling
- ☐ Difficulty Walking
- ☐ Rashes
- ☐ Changes in Appetite
- ☐ Poor Sleep
- ☐ Fatigue
- ☐ Muscle Weakness
- ☐ Joint Pain
- ☐ Genital Numbness
- ☐ Bowel Accidents/Incontinence
- ☐ Mood Changes Agitation/Anxiety
- ☐ Bladder Accidents/Incontinence
- ☐ Bleeding/Bruising Problems
- ☐ Blurred Vision
- ☐ Dizziness
- ☐ Recent Chest Pain
- ☐ Shortness of Breath