



LOW BACK/HIP PAIN FORM

Name _____ Date _____ Age _____
Occupation _____ Employer Name _____ # Yrs Employed _____

1. Who referred you? _____
May we send a report? Yes [] No []

2. Who is your family doctor? _____
May we send a report? Yes [] No []

3. Emergency Contact (name, phone #, relation) _____

4. Is your back pain the result of a specific injury?
Yes [] No []
If yes; () work related () non-work related
Date of injury: _____

5. Brief history of illness:

6. Are you presently working? Yes [] No []
If yes; () full duties () light duties
If not presently working; date last worked _____

7. Do you have low back pain? Yes [] No []

8. Does the pain from your back radiate into your legs?
Yes [] No []
Circle which leg: Right Left

9. How long have you had symptoms?
(please place a number i.e. 6 days)
_____ days _____ weeks
_____ months _____ years

10. Since your symptoms began, has your back pain: (please circle)
Improved Stayed the same Has become worse

17. Have you experienced any of the following: If yes, please check.

- 1) General health problems Yes [] No []
a) [] unintentional weight loss b) [] change in appetite c) [] fever
d) [] sleeping problems
2) Head problems Yes [] No []
a) [] headache b) [] dizziness
2) Eye problems Yes [] No []
c) [] blurred vision d) [] double vision e) [] glasses f) [] contact lenses
g) [] glaucoma
2) Ear problems Yes [] No []
h) trouble with hearing i) [] vertigo j) [] tinnitus k) [] recent infection
2) Mouth & Throat problems Yes [] No []
l) [] sore throat m) [] tooth infection n) [] hoarseness
o) [] difficulty swallowing p) [] allergies/hay fever
3) Neck problems Yes [] No []
a) [] neck masses or lumps b) [] swollen glands c) [] thyroid disease

11. Have you ever had back pain before? Yes [] No []
If yes, explain when, how treated and did it completely go away? _____

12. Do you have any trouble controlling your bowel or bladder function (i.e. urinating or defecating without knowing it)?
Yes [] No []
If yes, for how long? _____

Table with 4 columns: Treatment, Yes, No, Did it help? (Yes/No). Rows include Physical therapy, Chiropractic, Braces, Injection, Medication.

List any previous spine surgery, the date performed, hospital, surgeons name and describe the surgical procedure as you understand it. _____

14. Have you seen any other physicians for this condition?
Yes [] No []
List physician(s) names: _____

15. Which component of your pain is worse? (please circle)
Back Pain Leg Pain

16. Are you allergic to any medications or are there any medications you cannot tolerate? Yes [] No []
List: _____

- 4) Respiratory problems (breathing) Yes [] No []
a) [] cough b) [] shortness of breath c) [] asthma d) chronic bronchitis
e) [] Pulmonary emboli f) [] emphysema g) [] tuberculosis
5) Cardiovascular problems (heart) Yes [] No []
a) [] chest pain b) [] palpitations c) [] heart murmur d) heart failure
e) [] hypertension f) [] edema g) [] peripheral vascular disease
h) [] leg cramps i) [] blood clot in legs j) [] shortness of breath w/o activity
k) [] pacemaker l) [] stents m) [] open heart surgery
6) Gastrointestinal problems (stomach) Yes [] No []
a) [] abdominal pain b) [] heartburn c) [] nausea d) [] vomiting
e) [] constipation f) [] diarrhea g) [] stomach ulcers
h) [] gallbladder disease i) [] hepatitis
7) Genitourinary problems (kidney) Yes [] No []
a) [] frequency of urination b) [] burning or pain on urination
c) [] urinary infections d) [] kidney stones e) [] incontinence

- 8) Neurological problems (nerves) Yes No
 a) fainting b) seizures c) fatigue d) weakness
 e) numbness/loss of sensation f) tingling/pins & needles
 g) loss of bladder control

- 9) Hematological problems (blood) Yes No
 a) anemia b) easy bruising c) easy bleeding

18) Do you have any history of ulcers in your stomach?
 If yes, list: _____

- 19) Do you have any intolerance to aspirin, Motrin, Advil or other arthritis medication Yes No

20) Any previous surgery? Yes No
 If yes, list : _____

21) Are you taking any medications (including vitamins, Tylenol oral contraceptives – any type of medication in pill or liquid form)? If so, please list: _____

- 10) Endocrine problems (thyroid) Yes No
 a) feel cold all the time b) feel hot when others do not
 c) increased appetite d) increased fatigue
 e) unwanted weight change f) diabetes

- 11) Cancer Yes No
 a) breast b) prostate c) lung d) thyroid e) kidney f) other

22) Do you drink? If yes, how much?
 Beer Yes No _____
 Wine Yes No _____
 Liquor Yes No _____

23) Do you smoke:
 Cigarettes Yes No If yes, how much? _____
 Cigars Yes No If yes, how much? _____

24) Do you chew tobacco? Yes No _____

25) Do you use illicit drugs? Yes No _____

26) Diagnostic studies, dates, and locations:
 Plain x-rays _____
 CAT Scans _____
 MRIs _____
 EMGs _____
 CT myelograms _____

27) Height _____ Weight _____

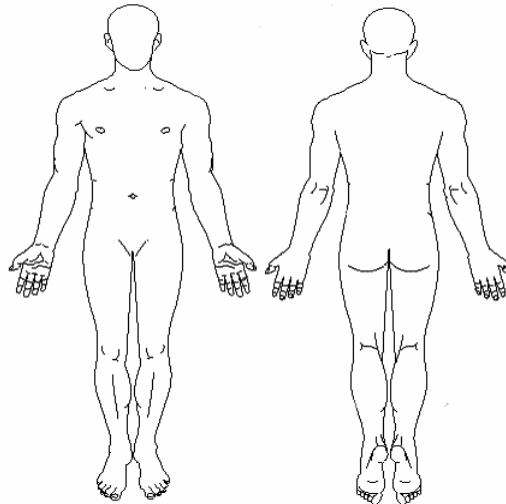
The documented information is true and complete to the best of my knowledge.

Signature _____ **Date** _____

PATIENT PAIN DRAWING

Where is your back pain now? Mark the areas on your body where you feel the sensation described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching ▼▼▼	Numbness ===	Pins & Needles ooo	Burning xxx	Stabbing ///
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Front

Back

How bad is your pain? Please mark an X on the body from where the pain is worse now. Please mark on the scale from 1-10 how bad your pain is now:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain