

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark all areas on your body where you feel the described sensations - using the appropriate symbol.

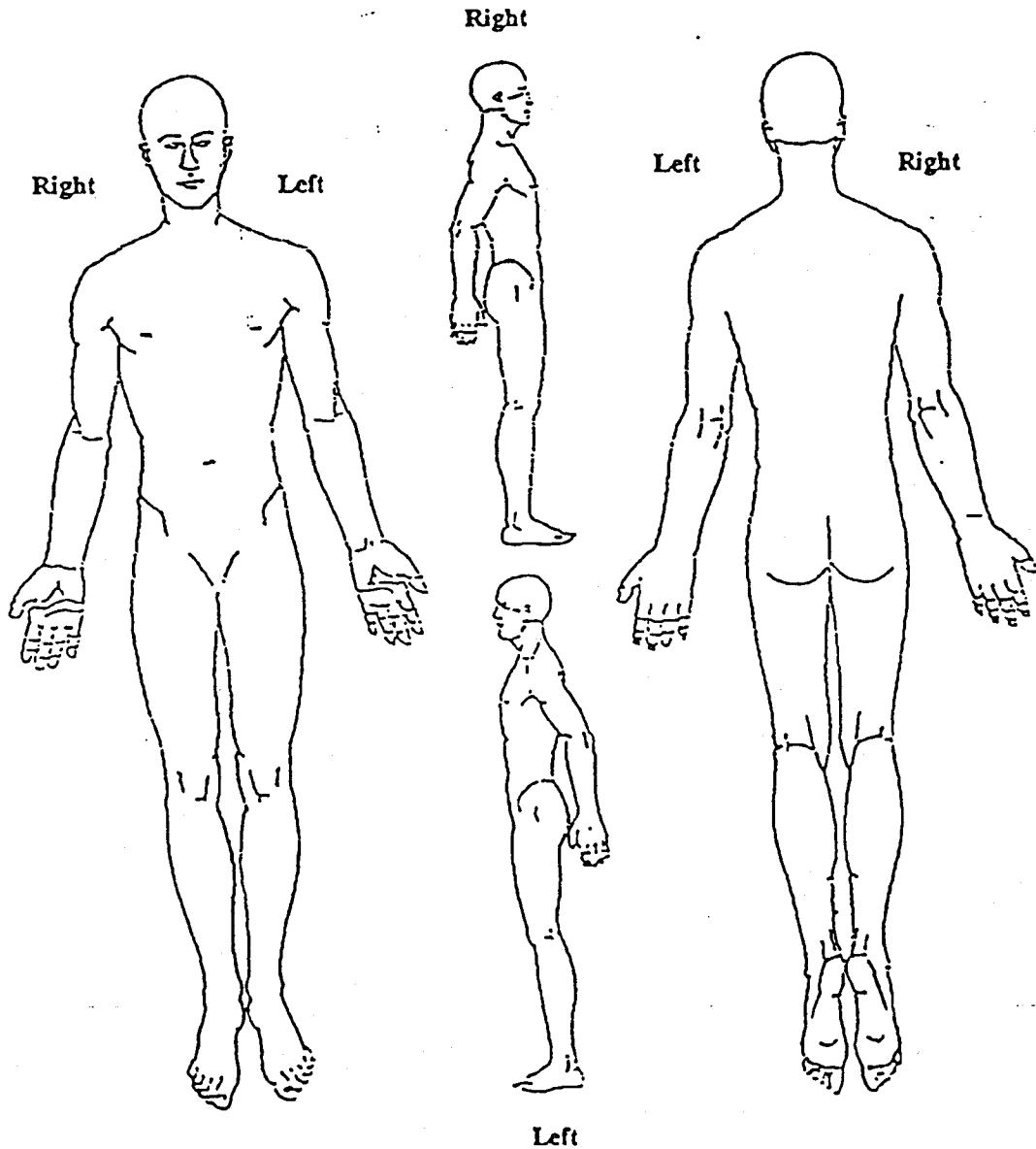
Numbness           =====

Burning            xxxxx

Stabbing           ////

Pins & Needles    oooo

Ache                ^^^^



\* Please see other side\*

PLEASE MARK OR ANSWER EACH QUESTION

Your occupation ? \_\_\_\_\_

Are you working?  Yes  No If not, what was the last day you worked? \_\_\_\_\_

Are you not able to work because of your back/neck?  Yes  No

Do you have an attorney related to this injury ?  Yes  No

If work or motor vehicle related, is this injury in litigation?  Yes  No

Does your pain interfere with daily living activities?  Yes  No

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

How bad is your back/leg pain with activity?    None Worst  
0 1 2 3 4 5 6 7 8 9 10

How bad is your neck/arm pain?    None Worst  
0 1 2 3 4 5 6 7 8 9 10

How bad is your pain at night?    None Worst  
0 1 2 3 4 5 6 7 8 9 10

How far can you walk without pain? \_\_\_\_\_

How long can you stand? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

How long can you sit? \_\_\_\_\_ Hours \_\_\_\_\_ Minutes

Percentage pain (Total is 100%) Neck \_\_\_\_\_ Arms/Hands R \_\_\_\_\_ /L \_\_\_\_\_  
Back \_\_\_\_\_ Legs R \_\_\_\_\_ L \_\_\_\_\_

Have you had any previous treatment for your back ?  Yes  No Neck ?  Yes  No

If yes: Physical Therapy  Yes  No Chiropractor  Yes  No

Steroid Injection  Yes  No Other \_\_\_\_\_

Have you had previous back/neck surgery ?  Yes  No If yes, when? \_\_\_\_\_