

SPINE PATIENT ENCOUNTER FORM

NAME: _____ DOB: _____ DATE: _____

1. WHAT KIND OF PAIN ARE YOU HAVING? (CHECK ALL THAT APPLY)	PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING. (CHECK ALL THAT APPLY)	RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN. (CIRCLE)
	Sharp Dull Aching Stabbing Throbbing Numbness Shooting Pain	
<input type="checkbox"/> BACK PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> LEFT LEG PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> RIGHT LEG PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> LEFT ARM PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> RIGHT ARM PAIN	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10

2. HOW LONG HAVE YOU BEEN HAVING PAIN? ___ DAYS ___ WEEKS ___ MONTHS ___ YEARS

3. WHAT IS THE RATIO OF BACK TO LEG PAIN? <input type="checkbox"/> 100% BACK/ 0% LEG PAIN <input type="checkbox"/> 75% BACK/ 25% LEG PAIN <input type="checkbox"/> 50% BACK/ 50% LEG PAIN <input type="checkbox"/> 25% BACK/ 75% LEG PAIN <input type="checkbox"/> 0% BACK/ 100% LEG PAIN <input type="checkbox"/> NO BACK/LEG PAIN	WHAT IS THE RATIO OF NECK TO ARM PAIN? <input type="checkbox"/> 100% NECK/ 0% ARM PAIN <input type="checkbox"/> 75% NECK/ 25% ARM PAIN <input type="checkbox"/> 50% NECK/ 50% ARM PAIN <input type="checkbox"/> 25% NECK/ 75% ARM PAIN <input type="checkbox"/> 0% NECK/ 100% ARM PAIN <input type="checkbox"/> NO NECK/ARM PAIN
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4. ARE YOUR SYMPTOMS DUE TO AN INJURY YES NO
 IF THE ANSWER IS YES, PLEASE GIVE DATE AND EXPLAIN THE DETAILS REGARDING THE INJURY:

5. IF YOU ARE SUFFERING FROM BACK OR NECK PAIN, WHAT PERCENTAGE OF THE PAIN IS RELIEVED WHEN LYING DOWN IN YOUR MOST COMFORTABLE POSITION?

 100% RELIEF WHEN LYING DOWN
 75% RELIEF WHEN LYING DOWN
 50% RELIEF WHEN LYING DOWN
 25% RELIEF WHEN LYING DOWN
 0% RELIEF WHEN LYING DOWN

6. WHAT POSITIONS/ACTIVITIES AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)	RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN (CIRCLE).
<input type="checkbox"/> STANDING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> WALKING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> SITTING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> FORWARD BENDING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> BACKWARD BENDING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> SIDE BENDING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> GETTING OUT OF BED	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> COUGH, SNEEZE, STRAIN	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> LIFTING	<input type="checkbox"/> 1 2 3 4 5 6 7 8 9 10

7. PLEASE DESCRIBE YOUR WALKING TOLERANCE:

 I CAN WALK INDEFINITELY.
 I CAN WALK UP TO AN HOUR.
 I CAN WALK UP TO 30 MINUTES.
 I CAN WALK UP TO 15 MINUTES.
 I CAN WALK LESS THAN 5 MINUTES.

8. HAVE YOU NOTICED ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- CLUMSINESS
- DROPPING OBJECTS MORE FREQUENTLY
- WORSENING HANDWRITING
- UNSTEADY WHEN WALKING
- NONE OF THE ABOVE

9. HAVE YOU GAINED OR LOST WEIGHT RECENTLY? YES NO
IF YES, THEN OVER WHAT TIME PERIOD? _____

10. WHAT TREATMENTS HAVE YOU HAD FOR YOUR CURRENT SYMPTOMS? (CHECK ALL THAT APPLY)

(CHECK ALL THAT APPLY)

- PHYSICAL THERAPY
- EPIDURAL STEROID INJECTIONS
- FACET BLOCKS
- NSAIDS (IBUPROFEN, NAPROXEN, CELEBREX, LODINE, ETC.)
- NARCOTICS (DARVOGET, VICODIN, PERCOGET, OXYCONTIN, METHADONE, ETC.)
- ULTRAM / ULTRACET
- CHIROPRACTOR MANIPULATION
- BRACES

DID THE TREATMENT HELP?

- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO

11. HAVE YOU HAD ANY PREVIOUS SPINE SURGERIES? YES NO
IF YES, PLEASE LIST THE NAME OF THE PROCEDURE, THE DATE AND THE SURGEON:

12. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- FEVERS
- CHILLS
- NIGHT SWEATS
- WEIGHT LOSS
- NONE OF THE ABOVE

13. DOES THE PAIN WAKE YOU UP FROM SLEEP AT NIGHT? YES NO

14. HAVE YOU EVER LOST BOWEL OR BLADDER CONTROL? YES NO

15. PLEASE SHADE IN THE AREAS ON THE DIAGRAMS THAT CORRESPOND TO YOUR AREAS OF PAIN ON YOUR BODY.

