

SPINE PATIENT ENCOUNTER FORM

NAME: _____ DATE: _____

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

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

<p>3. WHAT IS THE RATIO OF BACK TO LEG PAIN?</p> <p><input type="checkbox"/> 100% BACK/ 0% LEG PAIN</p> <p><input type="checkbox"/> 75% BACK/ 25% LEG</p> <p><input type="checkbox"/> 50% BACK/ 50% LEG PAIN</p> <p><input type="checkbox"/> 25% BACK/ 75% LEG PAIN</p> <p><input type="checkbox"/> 0% BACK/ 100% LEG PAIN</p> <p><input type="checkbox"/> NO BACK/LEG PAIN</p>	<p>WHAT IS THE RATIO OF NECK TO ARM PAIN?</p> <p><input type="checkbox"/> 100% NECK/ 0% ARM PAIN</p> <p><input type="checkbox"/> 75% NECK/ 25% ARM PAIN</p> <p><input type="checkbox"/> 50% NECK/ 50% ARM PAIN</p> <p><input type="checkbox"/> 25% NECK/ 75% ARM PAIN</p> <p><input type="checkbox"/> 0% NECK/ 100% ARM PAIN</p> <p><input type="checkbox"/> NO NECK/ ARM PAIN</p>
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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 AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)

STANDING

WALKING

SITTING

FORWARD BENDING

BACKWARD BENDING

SIDE BENDING

GETTING OUT OF BED

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 NOTICED ANY CHANGE IN YOUR BODY SHAPE RECENTLY? YES NO
IF YES, THEN OVER WHAT TIME PERIOD? _____

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

(CHECK ALL THAT APPLY)

- PHYSICAL THERAPY
- EPIDURAL STEROID INJECTIONS
- FACET BLOCKS
- NSAIDS (MOTRIN, IBUPROFEN, CELBREX, BEXTRA, VIOXX, LODINE, ETC.)
- NARCOTICS (LORTAB, DARVOCET, VICODIN, PERCOCET, OXYCONTIN, ETC.)
- ULTRA / 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.

