Austin Brain & Spine

SPINE HISTORY

Patient Name: _____

Chief Complaint: (circle one) Neck/upper extremity/arm pain symptoms☐ Back/lower extremity/leg pain symptoms☐	
When did the pain start? (approximate date)	Did the pain start **gradually** or **suddenly?** (circle one) ☐ ☐
How did it start? (circle one)☐Auto accident ☐Fall☐Lifting☐Bending☐Pulling☐Twisting ☐Hit in back☐Reaching ☐Other: _____	If injury, describe:
Neck/Upper extremity/Arm Pain symptoms	
Do you have **arm pain**? (circle one) Yes☐No☐ Which arm? Right☐Left☐Both☐	Do you have **numbness** in your arms?(circle one) Yes☐No☐
Do you have **arm weakness**? (circle one) Yes☐No☐	If yes, describe weakness:
What percentage is **ARM** pain vs. **NECK** pain? _____% ARM + _____% NECK = 100%	
What percentage is **RIGHT ARM** pain vs. **LEFT ARM** pain? _____% RIGHT + _____% LEFT = 100%	
Back/Lower extremity/Leg Pain symptoms	
Do you have **leg pain**? (circle one) Yes☐No☐ Which leg? Right☐Left☐Both☐	Do you have **numbness** in your legs? (circle one) Yes☐No☐
Do you have **leg weakness**? (circle one) Yes☐No☐	If yes, describe weakness:
What percentage is **LEG** pain vs. **BACK** pain? _____% ARM + _____% NECK = 100%	
What percentage is **RIGHT LEG** pain vs. **LEFT LEG** pain? _____% RIGHT + _____% LEFT = 100%	

MY PAIN IS… (circle if applicable)			
With cough or sneeze	Better ☐	Worse ☐	No different ☐
Sitting	Better ☐	Worse ☐	No different ☐
Bending forward	Better ☐	Worse ☐	No different ☐
Bending backward	Better ☐	Worse ☐	No different ☐
Lying on back	Better ☐	Worse ☐	No different ☐
Standing	Better ☐	Worse ☐	No different ☐
Walking	Better ☐	Worse ☐	No different ☐ *If worse, how long are you able to walk before the pain starts?*

HAVE YOU HAD? (circle if applicable)	
NSAIDS	Yes☐No☐Better☐Worse☐No different☐
Oral steroids (i.e. Medrol, prednisone)	Yes☐No☐Better☐Worse☐No different☐
Narcotic pain medications	Yes☐No☐Better☐Worse☐No different☐
Lyrica/gabapentin	Yes☐No☐Better☐Worse☐No different☐
Muscle relaxants	Yes☐No☐Better☐Worse☐No different☐
Physical therapy	Yes☐No☐Better☐Worse☐No different☐ *Duration:* _____
Chiropractor	Yes☐No☐Better☐Worse☐No different☐ *Duration:* _____
Home exercise program	Yes☐No☐Better☐Worse☐No different☐ *Duration:* _____
Bracing	Yes☐No☐Better☐Worse☐No different☐ *Duration:* _____
Injections	Yes☐No☐Better☐Worse☐No different☐
If yes, who did the injections and when:	
Previous spine surgery	Yes☐No☐Better☐Worse☐No different☐
Have you had any of the following for your neck/back? (circle if applicable)	
Emergency room ☐	If yes, when and where?
Pain management ☐	If yes, when and where?
MRI ☐	If yes, when and where?
XRAY ☐	If yes, when and where?
CT Scan ☐	If yes, when and where?
Myelogram ☐	If yes, when and where?
EMG (nerve conduction study) ☐	If yes, when and where?
Bone Scan ☐	If yes, when and where?

Pain Scale:

Instructions: Please rank your pain on average over the past week on a scale of 0-10, 0= no pain, 10= worst pain of entire life (circle one)

0 1 2 3 4 5 6 7 8 9 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Patient name: _____ **DOB** _____ **Date**: _____