

Back, Neck & Hip Information Sheet

(please fill out entire sheet)

Patient Name: _____ Today's Date: _____ Age: _____ Height: _____ Weight: _____
 (Last) (First) (MI)

Progression of Symptoms:

When did your pain begin? _____

Did your pain begin as a result of an accident? Yes No, If Yes, please describe how this accident occurred: _____

How often do you have pain? _____

What helps it go away? _____

Have you missed work because of this pain? Yes No, If Yes, how much time? _____ Last date worked? _____

How long has your current pain been present? _____ Describe your pain: _____

Does your pain radiate into other areas besides the back or neck? Yes No, If Yes, please describe: _____

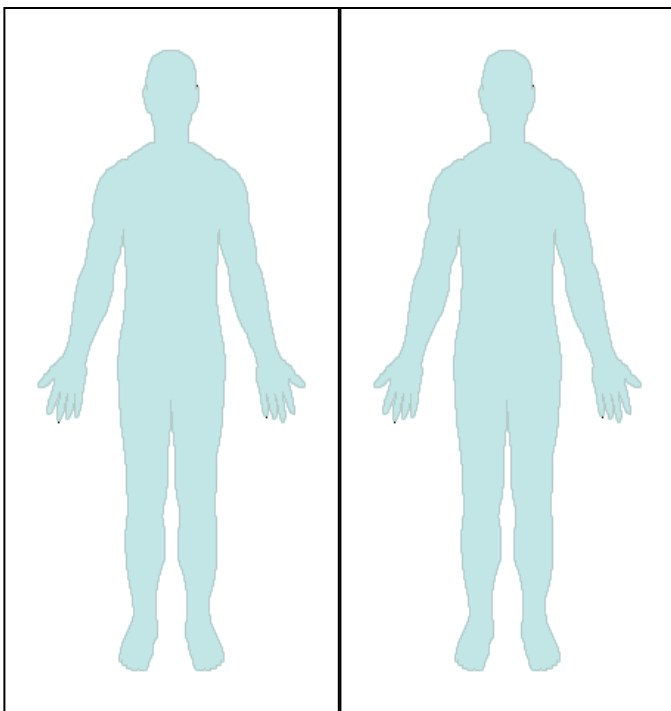
If it radiates down the leg or arm, does it radiate past the knee or elbow? Yes No Does it awaken you at night? Yes No

Is your pain reduced by rest? Yes No Does your pain increase while you? Walk Sit Stand Lie Down ...If you have

pain walking, is it relieved by stopping or must you sit to relieve the pain? Yes No Do you suffer from dizzy spells? Yes No

Mark the area on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiating pain.

Include all affected areas. **Just to complete the picture, please fill in the person's face.**



Numbness /////
 Burning xxxxxxx
 Stabbing ooooooooo
 Pins & Needles -----

Where do you hurt the most? _____

Do you have weakness of arms and/or legs? Yes No, If Yes, please describe: _____

Do you have restless legs at night? Yes No, If Yes, please describe: _____

Have you lost control of your bowels and/or bladder? Yes No, If Yes, please describe: _____

List previous operations on your back, neck, hip, or abdomen? When? _____

Describe how your symptoms changed after surgery: _____

Have you had abdominal problems or infections? Yes No, If Yes, please describe: _____

Do you have a history of malignancy? Yes No, If Yes, please describe: _____

Men: Date of last rectal or proctoscopic exam _____ Please describe any abnormality: _____

Women: Date of last pelvic exam _____ Please describe any abnormality: _____



Treatments:

For this condition what treatments have you received?

Type of Surgery	Doctor	Where	Date	How did Your Symptoms Change after Surgery?

Have you seen a Chiroprator for this problem? Yes No, If Yes, Who? _____ Did it help, describe? _____

Have you seen a Massage Therapist for this problem? Yes No, If Yes, Who? _____ Did it help, describe? _____

Have you seen an Acupuncturist for this problem? Yes No, If Yes, Who? _____ Did it help, describe? _____

Have you seen a Physical Therapist for this problem? Yes No, If Yes, Who? _____ Did the Physical Therapist treat you with? Ultrasound Massage Traction Tens Unit Electric StimDid it help, describe? _____

Do you have a Home Exercise Program? Yes No Are you on a Work Harding Program? Yes No
 Are taking any Pain Medications? (list all prescription and over-the-counter) _____

Medical Records:

List all the doctors you have seen for this problem:

Name of Doctor	Address of Doctor	Phone # of Doctor	Date of Last Treatment

Have you had the following tests? If so, please list:

Name of Test	Name of Doctor that ordered Test	Where was the Test Performed	Date of Test
MRI			
Bone Scan			
Electrical Studies _____			
X-rays			

**** The Patient is responsible for bringing medical records, X-rays, MRI's ...etc to the appointment or you may have them sent to us, but you will be responsible for returning them.**