

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Spine Management

Please answer every question

Handwritten items must be entered **MANUALLY**. Do not fold this form.

Marking Instructions

Please use a #2 pencil. Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

Grid for patient's last name

PLEASE PRINT PATIENT'S FIRST NAME

Grid for patient's first name

PATIENT'S DATE OF BIRTH

Grid for patient's date of birth (Month, Day, Year)

THERAPY

Rate your BACK pain:

0 = no pain

Scale 0-10 with ovals for rating back pain

10 = worst pain imaginable

Rate the pain in your LEGS:

0 = no pain

Scale 0-10 with ovals for rating leg pain

10 = worst pain imaginable

Date symptoms began:

What caused the symptoms?

Have you tried medications for your symptoms?

Yes/No radio buttons for medications

Have you tried a back brace?

Yes/No radio buttons for back brace

What type?

EPIDURALS

Have you had any epidurals?

Yes/No radio buttons for epidurals

DATE & NAME of Provider:

How many epidurals have you had?

Radio buttons for number of epidurals (1, 2, 3, 4, 5, 5+)

What result did you receive from the epidurals?

Radio buttons for result of epidurals (sustained relief, temporary relief, no relief, worsening of pain)

PHYSICAL THERAPY

Have you tried physical therapy?

Yes/No radio buttons for physical therapy

LOCATION:

Date of last physical therapy visit:

Types of physical therapy:

Radio buttons for types of physical therapy (heat, ultrasound, exercise, traction)

Radio buttons for other types of physical therapy (massage, electrical stimulation, stretching)

other:

REFERRALS

Have you had a neurology evaluation?

Yes/No radio buttons for neurology evaluation

DATE & NAME of Provider:

Have you had any pain management?

Yes/No radio buttons for pain management

DATE & NAME of Provider:

Have you seen a chiropractor?

Yes/No radio buttons for chiropractor

DATE & NAME of Provider:

Have you seen an acupuncturist?

Yes/No radio buttons for acupuncturist

DATE & NAME of Provider:

EMG (Electromyography)

Have you had an EMG?

Yes/No radio buttons for EMG

DATE & LOCATION:

What were the results of the EMG?