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## BACK/NECK FORM

TO BE COMPLETED BY PATIENT

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<b>Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Today's Date</b>
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Dominant Hand: R \_\_\_ L \_\_\_ Age: \_\_\_ Sex: \_\_\_

### CURRENT COMPLAINTS

Please describe your current symptoms (for example back pain, leg pain, neck pain arm pain)

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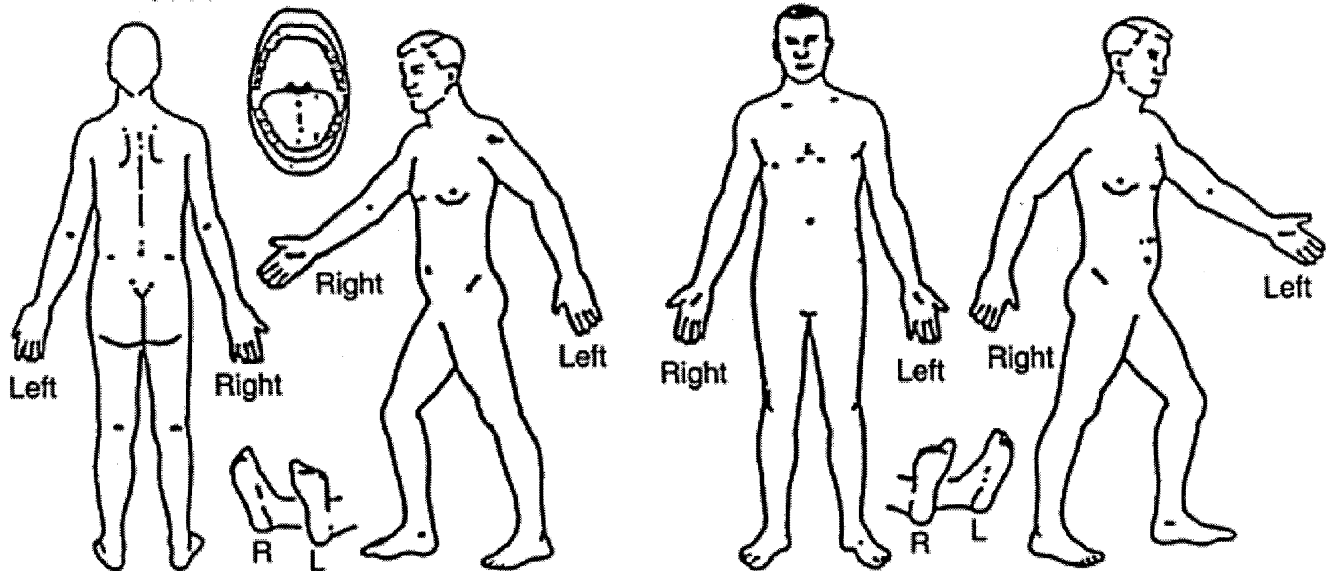
Out of a 100%, what percent of pain do you have in your:

<b>Neck Pain versus Arm Pain</b>	_____ % Neck Pain	+	_____ % Arm Pain	=	<b>100%</b>
<b>Back Pain versus Leg Pain</b>	_____ % Back Pain	+	_____ % Leg pain	=	<b>100%</b>

## PAIN DIAGRAM

Mark the areas on your body where you now feel your typical pain. Include all affected areas. Use the appropriate symptoms indicated below.

ACHE >>>>      BURNING XXXX    NUMBNESS ====    PINS & NEEDLES OOOO    STABBING /////



What do the following activities do to your neck/back and arm/leg pain? (Please check all that apply)

	No Change	Relieves Pain	Increases Pain
<b>Sitting</b>			
<b>Walking</b>			
<b>Standing</b>			
<b>Lying Down</b>			
<b>Bending Forward</b>			
<b>Bending Backwards</b>			
<b>Lifting</b>			
<b>Straining</b>			
<b>Sneezing</b>			
<b>Coughing</b>			

### INTENSITY OF PAIN

**0 = No Pain and  
10 = Most severe pain imaginable**

**Circle the number that applies**

BACK	At Worse At Best	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10
LEGS	At Worse At Best	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10
NECK	At Worse At Best	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10
ARMS	At Worse At Best	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

**ONSET**

Approximate date when your back/neck pain began? \_\_\_\_\_

How did this most current episode of back/neck pain occur? Check all that apply.

- Gradual Onset
- Reaching
- Lifting
- Don't Know
- Fall
- Twisting
- Pushing
- Other
- Direct Blow
- Bending
- Pulling

Was your injury the result of one of the following?

- Vehicle Accident
- Recreational Accident
- No Known Cause
- On the Job Injury
- Non- Work Related Incident

Please briefly describe the onset of your back/neck pain.

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**PROGRESSION**

How has your pain changed since its onset?

	<b>Much Improved</b>	<b>Somewhat Improved</b>	<b>No Change</b>	<b>A Little Worse</b>	<b>Much Worse</b>
<b>BACK</b>					
<b>NECK</b>					
<b>LEGS</b>					
<b>ARMS</b>					

How would you describe your overall severity of pain?

- Mild** Nuisance Pain
- Moderate**; I am having difficulty dealing with it
- Mild to Moderate**, but I can live with it
- Severe**; it is ruining my quality of life

## PREVIOUS TREATMENT

### MEDICATION PRESCRIBED

Indicate what medications have been prescribed and what kind of relief they provided.

	NO HELP	SOME RELIEF	MUCH RELIEF
<b>Anti-inflammatory:</b> (Example Advil, Ibuprofen, Naprosyn, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Muscle Relaxers:</b> (Soma, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pain Medications:</b> (Percocet, Lortab, Norco, Vicodin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### THERAPY PRESCRIBED

	WORSENERD	NO HELP	SOME RELIEF	MUCH RELIEF
<b>PHYSICAL THERAPY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BEDREST</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TRACTION</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TENS UNIT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EXERCISE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INJECTIONS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACCUPUNCTURE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BRACING</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ICE PACK</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAT PACK</b>	<input type="checkbox"/>			
<b>ULTRASOUND</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CHIROPRACTIC (NAME)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### STUDIES

Indicate which of the following tests or treatments you have had for this problem.

TESTS	YES	NO	DATE	LOCATION
<b>X-RAYS</b>	YES	NO		
<b>MRI</b>	YES	NO		
<b>CT SCAN</b>	YES	NO		
<b>DISCOGRAM</b>	YES	NO		
<b>BONE SCAN</b>	YES	NO		
<b>NERVE BLOCK</b>	YES	NO		
<b>EPIDURAL/STEROID</b>	YES	NO		
<b>EMG</b>	YES	NO		

**OTHER** \_\_\_\_\_

**SPINE SURGERY**

	<b>PROCEDURE</b>	<b>SURGEON</b>	<b>DATE</b>	<b>OUTCOME</b>
1.	_____			
2.	_____			
3.	_____			

**OCCUPATIONAL HISTORY**

**Employer:** \_\_\_\_\_ **Date of Hire** \_\_\_\_\_

**Usual Occupation:**  
\_\_\_\_\_

**Briefly describe your job:**  
\_\_\_\_\_

**Prior Occupation:** \_\_\_\_\_ **Date of Hire:** \_\_\_\_\_

**Reason for leaving:**  
\_\_\_\_\_

**How physically demanding is your job? Check one**

\_\_\_\_\_ **Very Heavy (frequently lifting > 100#)**  
\_\_\_\_\_ **Heavy (frequently lifting > 75#)**  
\_\_\_\_\_ **Moderate (frequently lifting > 50#)**  
\_\_\_\_\_ **Light (frequently lifting < 20#)**  
\_\_\_\_\_ **Sedentary (essentially no lifting)**

**Does an attorney assist you with your injury claim?**       **YES**       **NO**       **N/A**

**If yes, please give name and address of attorney:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle a number to indicate how much of a problem you are having with each of the following:

<b>Anxiety</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Depression</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Irritability</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Insomnia</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>

**Please sign and date this form**

\_\_\_\_\_  
**Signature** **Date**

\*\*\*\*\* Physical Findings, (M.D. use only) \*\*\*\*\*

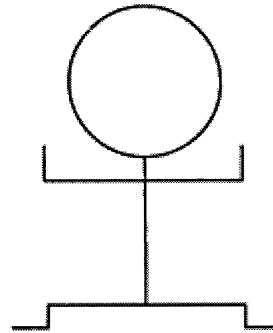
MOTOR

ABN MUSCLE	R	L

SENSORY

ABN LEVEL	R	L

FLEXION	SLR	R	L
	DEGREES POSITIVE		
EXTENSION			
ROTATION L R	SITTING		
SIDE R L			



X-Ray  
MRI / CT

Other

Impression

Plan

