PREMIER SPINE & SPORTS MEDICINE

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HISTORY OF PRESENT ILLNESS

Reason for your visit today: _____

_____

Where is your pain located (neck/back)? _____

Does the pain travel (i.e. down the backk of your leg)? _____

How long have you had these present symptoms? _____ day(s) _____ week(s) _____ month(s) _____ year(s)

Is this related to an accident (car / work)? Yes / No

If yes, how did the accident occur? _____

_____

If no, how did the symptoms occur? _____

Have you ever been treated for this problem? Yes / No

If yes, who did you receive treatment from? _____

Rate your pain from 0-10. (0 is no pain; 10 is severe pain) _____ Does your pain: come and go / constant

Please describe the pain: Sharp / Stabbing / Dull / Aching / Throbbing / Electric / Pressure / Stiffness

What makes the pain worse? Sitting / Standing / Walking / Driving / Bending / Stairs / Lying down

Sitting to standing transitions / Other _____

What makes the pain better? Lying down / Rest / Walking / Standing / Sitting / Stretching / Pain meds

Physical therapy / Acupuncture / Other _____

Do you have numbness, tingling, or burning sensations? Yes / No If yes, where is it located? _____

Do you have any weakness of your arms or legs? Yes / No If yes, where is it located? _____

Do you have any new bladder or bowel changes? Yes / No

_____

Do you have any past accidents (car/work) to report? Yes / No

If yes, when was it and did you receive any treatment? _____

Did you have any of your current pain symptoms prior to this accident? Yes / No