SOUTHWEST Spine & Sports

H: ____________

W: ____________

BP: ____________

P: ____________

NAME: ________________________________ **DATE:** ______________

Describe any symptom changes since your last visit.
____
____
____

What makes your symptoms:
Worse: ________________________________
Better: ________________________________

Since your last visit, are you:
_______Better by _______%
_______Worse by_______%
_______Same

Circle the number that best describes your current pain with "10" *being the most severe*.

NECK/ARM	0	1	2	3	4	5	6	7	8	9	10
BACK/LEG	0	1	2	3	4	5	6	7	8	9	10

How long/far can you:
Sit____________Stand__________Walk__________

If you are taking medications, please list (include dosage):
____
____
____

Have you had any medical testing since your last visit? No_____Yes_____ (Please List)
____
____

Have you seen any other physicians since your last visit? No_____Yes_____(Who/ What reason?)
____
____

Are you currently working? Yes_____No_____
Any work restrictions? ________________________

If you have had an injection since your last visit, how would you rate your satisfaction (circle one)?

1. Not at all satisfied
2. Not very satisfied
3. Neither satisfied nor dissatisfied
4. Mostly satisfied
5. Very satisfied

Are you in Physical Therapy? Yes_____No_____
If yes, how often? ________________________

Are you doing a home exercise program?
Yes_____ No_____
If yes, how often? ________________________

PAIN DIAGRAM

Please mark the areas on the diagram using the appropriate symbols. These symbols describe what you feel.

Numbness	Pins & Needles	Burning	Stabbing/Sharp	Aching
OOO	••••	XXX	!!!	- - - -