NAME:_____ DATE:_____

1. RATE YOUR PAIN: 0= NO PAIN 10= EXTREME PAIN

A. AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)
B. AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)

2. WHAT MAKES THE PAIN WORSE? (PLEASE CHECK ALL THAT APPLY)

_____BENDING _____PROLONGED SITTING

_____TWISTING _____PRLONGED STANDING

_____COUGHING _____STRAINING AT STOOL

_____SNEEZING _____WALKING

_____CALF CRAMPING WHILE WALKING

TURING HEAD: ___RIGHT ___LEFT ___UP ___DOWN

3. WHAT MAKES THE PAIN BETTER?

_____REST _____MEDICATIONS

_____ LYING DOWN _____HEAT

_____BRACE _____COLLAR

_____ LYING ON SIDE WITH HIPS AND KNEES CURLED UP

4. IS THE PAIN USUALLY WORSE: (CHECK ALL THAT APPLY)

_____IN THE MORNING WHEN YOU FIRST GET UP

_____AS THE DAY PROGRESSES

_____AT NIGHT IN BED

_____DOES IT WAKE YOU UP FROM SLEEPING?

5. ANY OTHER JOINTS HURT? (DESCRIBE)_____

6. HAVE YOU LOST ANY WEIGHT? ___YES ___NO HOW MUCH?_____

7. HAVE YOU HAD ANY BOWEL OR BLADDER PROBLEMS? ___YES ___NO

8. ANY TROUBLE WALKING? ___LEG PAIN ___LEG UNSTEADINESS

9. ANY NUMBNESS OR TINGLING? ___NO ___YES WHERE?

10. ANY WEAKNESS? ___NO ___YES WHERE?

11. HAVE YOU EVER HAD NECK OR BACK PAIN IN THE PAST? ___NO ___YES ___BACK ___NECK

HOW MANY TIMES? _____ WHEN WAS THE LAST EPISODE?_____

12. PLEASE LIST ANY PRIOR INJECTIONS OR SURGERIES.

PROCEDURE_____ HOSPITAL_____
PROCEDURE_____ HOSPITAL_____