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

Direction of Feed

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

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

THERAPY

Rate your BACK pain: 0 = no pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 10 = worst pain imaginable

Rate the pain in your LEGS: 0 = no pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 10 = worst pain imaginable

Date symptoms began: _____

What caused the symptoms? _____

Have you tried medications for your symptoms?
○ yes ○ no

Have you tried a back brace?
○ yes ○ no

What type? _____

EPIDURALS

Have you had any epidurals?
○ yes ○ no

DATE & NAME of Provider: _____

How many epidurals have you had?
○ 1 ○ 2 ○ 3
○ 4 ○ 5 ○ 5+

What result did you receive from the epidurals?
○ sustained relief ○ no relief
○ temporary relief ○ worsening of pain

PHYSICAL THERAPY

Have you tried physical therapy?
○ yes ○ no

LOCATION: _____

Date of last physical therapy visit: _____

Types of physical therapy:
○ heat ○ exercise
○ ultrasound ○ traction
○ massage
○ electrical stimulation
○ stretching

other: _____

REFERRALS

Have you had a neurology evaluation?
○ yes ○ no

DATE & NAME of Provider: _____

Have you had any pain management?
○ yes ○ no

DATE & NAME of Provider: _____

Have you seen a chiropractor?
○ yes ○ no

DATE & NAME of Provider: _____

Have you seen an acupuncturist?
○ yes ○ no

DATE & NAME of Provider: _____

EMG (Electromyography)

Have you had an EMG?
○ yes ○ no

DATE & LOCATION: _____

What were the results of the EMG? _____