



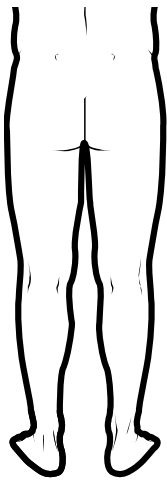
SPURLOCK

CHIROPRACTIC CENTRE

Low Back/Hip/Leg Complaints

Today's Date: ___ / ___ / ___ Name: _____

Circle the areas on your body where you feel the described sensations, and mark with the appropriate letter(s).



For Office Use Only:

PAIN = P

NUMBNESS = N

TINGLES = T

Quality

1.) Reports

- Weakness left arm Weakness left leg Fever
- Weakness right arm Weakness right leg Sexual dysfunction
- Weakness both arms Weakness both legs
- Bowel dysfunction Bladder dysfunction

EXPLAIN _____

2.) Denies

- Weakness Bowel dysfunction Fever
- Sexual dysfunction Bladder dysfunction

EXPLAIN _____

3.) Overall Status

Describe how your pain has changed recently.

- No change Feels better Feels worse Requiring more medication

4.) Is this a similar or recurrent problem?

- Deny previous episodes Recurrent problem for _____ Similar to previous _____

5.) Please circle the number which best describes your pain level, or if the pain varies, list a range (0-No Pain and 10-Worst Pain):

0 1 2 3 4 5 6 7 8 9 10 or Range: _____

6.) Sensations

- Aching Burning Cramping Dullness Throbbing Feeling Asleep
- Heaviness Numbness Pins/Needles Sharpness Tingling Other _____

Name: _____ Date: _____

Duration

7.) How long have you had this current episode or symptoms? _____

How did it begin? _____

Timing

8.) What activities or positions **RELIEVE or DECREASE** your pain?

- Nothing Bending Backward Heating Pad Lying on Side Resting
- Movement Back Brace Hot Bath/Shower Sitting Walking
- Bending/Stooping Cold Packs Lying on Stomach Standing Lying on Back
- Other, describe: _____

9.) What activities or positions **INCREASE** your pain?

- Nothing Bending Backward Lying on Back Lifting Standing
- Movement Back Brace Heating Pad Lying on Side Resting
- Bending/Stooping Cold Packs Hot Bath/Shower Sitting Walking
- Cough/sneeze Lying on Stomach Straining w/ Bowel Movement Twisting
- Other _____

Previous Treatment

10.) Which of these treatments have **improved** your condition?

- Back Brace Bed Rest Chiropractic TENS/e-stim Exercise Facet Injection
- Meds OTC Pain Meds Steroid Meds Musc.Relaxers Neurontin, Lyrica Epidural Injection
- Phys Therapy Occ. Therapy Ultrasound Rhizotomy Traction Sacroiliac Injection
- Spinal Decomp. Therapy NSAIDs Heat Cold Pack Steroid Injection
- Restrict Activity Other _____

11.) Which of these treatments did **not improve** your condition?

- Back Brace Bed Rest Chiropractic TENS/e-stim Exercise Facet Injection
- Meds OTC Pain Meds Steroid Meds Musc.Relaxers Neurontin, Lyrica Epidural Injection
- Phys Therapy Occ. Therapy Ultrasound Rhizotomy Traction Sacroiliac Injection
- Spinal Decomp. Therapy NSAIDs Heat Cold Pack Steroid Injection
- Restrict Activity Other _____

12.) Which of these treatments are you currently receiving?

- Back Brace Bed Rest Chiropractic TENS/e-stim Exercise Facet Injection
- Meds OTC Pain Meds Steroid Meds Musc.Relaxers Neurontin, Lyrica Epidural Injection
- Phys Therapy Occ. Therapy Ultrasound Rhizotomy Traction Sacroiliac Injection
- Spinal Decomp. Therapy NSAIDs Heat Cold Pack Steroid Injection
- Restrict Activity Other _____

13.) Who were you previously treated by?

- N/A Neurosurgeon _____ Neurologist _____
- This Office Orthopedic Surgeon _____ Chiropractor _____
- Pain Clinic _____ Other _____

When was your most recent MRI, CT, or XRAY of problem area? _____

Where was it performed? _____

Office use only:

Which of these treatments have not been attempted or prescribed?

- Back Brace Bed Rest Chiropractic TENS/e-stim Exercise Facet Injection
- Meds OTC Pain Meds Steroid Meds Musc.Relaxers Neurontin, Lyrica Epidural Injection
- Phys Therapy Occ. Therapy Ultrasound Rhizotomy Traction Sacroiliac Injection
- Spinal Decomp. Therapy NSAIDs Heat Cold Pack Steroid Injection
- Restrict Activity Other _____