Patient Name: _____ Today's Date: _____

Birthdate: _____

Back Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of what is bothering you, what part of your spine bothers you and how it happened)

_____

_____

_____

What is the location of your symptoms: ☐None

☐Upper back ☐Mid Back ☐Lower back ☐Gluteal/buttock area

Check any areas of your body that your back symptoms radiate to: ☐None

☐Left Thigh ☐Right Thigh ☐Left Hip ☐Right Hip ☐Left Groin ☐Right Groin

☐Left Calf ☐Right Calf ☐Left Foot ☐Right Foot

Are your symptoms: ☐Recurring ☐Improving ☐Worsening

What is the severity of your symptoms: ☐Mild ☐Moderate ☐Severe ☐Incapacitating

☐Other _____

How often do your symptoms occur: ☐Constantly ☐Daily ☐Weekly ☐Randomly

☐Other _____

Select the quality/description of your back symptoms: ☐None

☐Ache ☐Numbness ☐Sharp

☐Shooting ☐Weakness ☐Other _____

Check all activities that aggravate your back symptoms: ☐None

☐Sitting ☐Bending

☐Standing ☐Lifting ☐Other _____

Check all items that make your back symptoms better: ☐None

☐Exercise ☐Movement ☐Lying Down ☐Pain Meds/Drugs ☐Rest ☐Changing Positions

☐Heat ☐Stretching ☐Ice ☐Over the counter medications

☐Other _____