INNOVATIVE SPINE CARE

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www.GotSpinePain.com

(Please Print Clearly)

Patient Pain History

Name ______________________________ DOB __________ Age ____ Date. ____________

Pain level today: 0 1 2 3 4 5 6 7 8 9 10

Previous back surgery? Yes No

Would you describe your pain as: Constant Intermittent

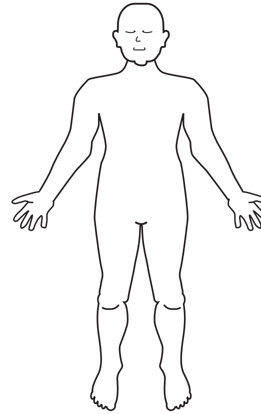
Does your pain disrupt your sleep? Yes No

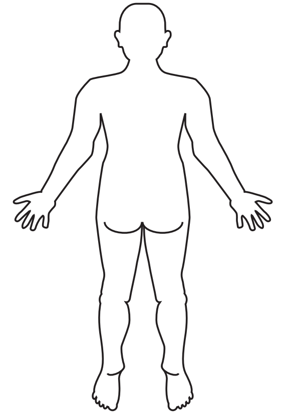
Where do you have pain? (indicate on the diagram at right)

How and when did your pain begin?

____

____





Indicate the location of your PAIN in black and NUMBNESS in RED on the diagram

What is the intensity of your pain? Burning Stabbing Pressure Electric Sharp Dull Aching Throbbing Gnawing Shooting Numbness Tingling Other ______________

What makes your pain worst? ____

What makes your pain better? ____

Can you walk? Yes No

Do you use an assistive device? Cane Walker Wheelchair Scooter Crutches None Other __________

What activities are you prevented from doing? ____

____

Please list all previously or currently used methods of pain management:

Acupuncture Massage Chiropractor Facet Block Trigger Point Injection Exercise Physical Therapy Epidural Injection Nerve Block Hypnosis Nerve Destruction Medication Acupressure Meditation Peripheral Nerve Block Other ____

Have you ever had an MRI done? Yes No

If yes, when and where? ____

Do you work? Yes No Retired

If yes, please describe job activities ____

Current Pharmacy ______________________________ Phone No. ______________

______________________ ______________ ______________________

Patient Signature Date Reviewed by: