Patient Name:______________________________

INNOVATIVE
SPINE CARE

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PHYSICAL COMPLAINTS FORM #1 OF 2

Primary Problem (worst):______________________(neck, mid-back, low back, arms, legs or headaches)
Secondary Problem:__________________________(neck, mid-back, low back, arms, legs or headaches)
Tertiary Problem (least):______________________(neck, mid-back, low back, arms, legs or headaches)

Pain Problem: (Neck__/Neck and arms__/Neck, arms and headaches__)
Description of pain:
aching___stabbing___pressure___jabbing___burning___grabbing___electric___other___
Location: left__/right__/middle__/both sides__/___side worse than___side/
Severity of pain: maximum____/10; average____/10; lowest level of pain____/10.
What increases pain?
Standing__sitting__lying down__bending neck__looking up over head__walking_____
lifting with arms__sitting to standing position__
Occurrence of pain: constant___/constant but waxes and wanes___/comes and goes___/related to activities___decreased pain in the morning and more pain later in the day___/variable pain in the morning___/pain increases during the day___/worst pain at bedtime___/awaken in night--pain___

Pain in arms: (Yes or No)______. How far down arms? Left_____________Right______________
Description of pain in the arms:
aching___stabbing___pressure___burning___electric___other_____________
Tingling in arms?_Yes___No___/Which arm(s)?______________________________________
Numbness in arms? Yes___No___/Which arm(s)?_____________________________________

Start of pain: date of injury___________/prior to the injury_____________________________
Severity of symptoms since incident: improving (%)_____/no change_____/getting worse(%)______

Pain problem: (mid-back or thoracic spine)
Description of pain:
aching___stabbing___pressure___jabbing___burning___grabbing___electric___other___
Location: left__/right__/middle__/both sides__/___side worse than___side/
Severity of pain: maximum____/10; average____/10; lowest level of pain____/10.
What increases pain? Standing__sitting__lying down__bending head down__looking up over head__walking__lifting__sitting to standing position__bending low back__lifting objects/weight___
Occurrence of pain: constant___/constant but waxes and wanes___/comes and goes___/related to activities___decreased pain in the morning and more pain later in the day___/variable pain in the morning___/pain increases during the day___/worst pain at bedtime___/awaken in night with pain__
Start of pain: date of injury___________/prior to the injury_____________________________
Severity of symptoms since incident: improving (%)_____/no change_____/getting worse (%)______

Pain problem (low back___/low back and buttocks___/low back and legs___/low back, buttocks and legs___.
Which buttock?______________/which leg?________________
Description of pain: aching___stabbing___pressure___jabbing___burning___grabbing___electric___ other___
Location: left__/right__/middle__/both sides__/___side worse than___side/
Severity of pain: maximum____/10; average____/10; lowest level of pain____/10.

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PHYSICAL COMPLAINTS FORM #2 OF 2

Pain in legs: (Yes or No) ______. How far down legs?
Left_________________________________Right____
Description of pain in the legs:
aching___stabbing___pressure___burning___electric___other_____________________________
Tingling in legs? _Yes___No___/Which leg(s)? _________Front/side/back/upper/lower leg_________
Numbness in legs? Yes___No___/Which leg(s)? _________Front/side/back/upper/lower leg_______
What increases pain? Standing__sitting__lying down__bending at waist__looking up/reaching over head___walking___lifting___sitting to standing position___

Occurrence of pain: constant___/constant but waxes and wanes___/comes and goes___/related to activities___decreased pain in the morning and more pain later in the day___/variable pain in the morning___pain increases during the day___/worst pain at bedtime___/awaken in night with pain__
Start of pain: date of injury___________/prior to injury________________________________
Severity of symptoms since incident: improving (%) _____/no change_____/getting worse (%) ____.

Pain problem (headaches): Yes___No___
Starting location: back of head___left___right___/side of head__left__right__/forehead & eyes__left__right__
Ending location: back of head___left___right___/side of head__left__right__/forehead & eyes__left__right__
Type of pain: aching__pressure__stabbing__ice pick__tight band around head__vice grips around head__other______________________
Associated weakness__tingling__numbness__speech difficulty__change in vision__
Severity of headache: maximum ___/10
Right before headache starts symptoms? Strange smell_______________sounds_____________
tastes_____________lights in eyes___________________
Frequency (how often) are the headaches? Daily___; #/week______; #/month________
What brings on the headaches? Moderate to severe neck pain____; fatigue____; exertion_____; menses_____other____________________________________
How long do headaches last? ____
What relieves the headaches? Lie down___sleep___stop working___unknown___medication (type) ____Fioricet___ibuprofen/Motrin__naproxen/Naprosyn__Aleve__aspirin/Excedrin__other_______
Total headaches in the one complete year/12 months before your injury____________(approximation)
Less intense than headaches since the incident___ (yes or no)
Same intensity as headaches since the incident___ (yes or no)
More intense headaches since the incident____ (yes or no)
Date headaches started: date of incident/injury__________prior to the incident/injury (date)_____
Symptoms since incident/injury: improving (%) _____/no change_____getting worse (%) ______
Frequency change (increase or decrease) ____/Severity of headache (increase or decrease)_______

MVA date: (1)_______...
(2)_______...
(3)_______...
(4)_______...
Slip & Fall date:________...
Worker's Comp Claim:________...

Trouble sleeping since incident? Yes___ No___

Problems: Fever/chills____ Excessive thirst/fatigue____ Dizzy spells____ Vision difficulties____ Sinus problems/sore throat/ear pain____ Chest pain____ Cough/shortness of breath/wheezing____ Abdominal pain/nausea/vomiting/rectal bleeding____ Painful urination/blood in urine/urine infection____ Swollen glands/blot clots/bleeding problem____ Depression/Bipolar/Schizophrenia/Personality disorder____. (Mark **Y** or **N** and circle your issue)