Patient Self History: Back Pain

1. When did your pain begin? (Exact date preferred.) ____________________________________________
2. Have you had similar symptoms before? □ Yes □ No If yes, how long ago? ________________
3. Is your pain . . . □ Improving □ Getting worse □ Staying the same
4. Are your symptoms the result of an injury? □ Yes □ No (If No, skip to question 5.)
   If Yes, briefly describe your injury (how and where it occurred):
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   Is this injury work related? □ Yes □ No
   Does this injury interfere with your work? □ Yes □ No
5. Using the symbols below, please mark the areas on your body where you feel the described sensations using the letters below. Please include all affected areas.
   A = Aching
   B = Burning
   S = Stabbing
   P = Pins and Needles
   W = Weakness
   N = Numbness
6. How would you rate your back pain in the past few days, using the scale below? ______/10
   0 = No pain 10 = extremely intense pain
   0------------1------------2------------3------------4------------5------------6------------7------------8------------9------------10
7. What makes the pain worse? Check all that apply.
   □ Sitting □ Sneezing □ Walking □ Mornings
   □ Bending □ Coughing □ Lying down □ Evenings
   □ Lifting □ Standing □ Twisting/turning □ Night
   What other things make your pain worse? ___________________________________________________
8. What makes the pain better? Check all that apply.
   □ Sitting  □ Standing  □ Bending forward
   □ Lying down  □ Walking  □ Medication (please list): ____________________
   □ Exercise  □ Walking with shopping cart
   What other things make your pain better? ________________________________

9. Do you exercise regularly? □ Yes  □ No

10. Do you have any of these symptoms?
    □ Yes □ No  Genital or rectal numbness
    □ Yes □ No  Changes in bowel/bladder control
    □ Yes □ No  Sexual dysfunction
    □ Yes □ No  Fever or chills
    □ Yes □ No  Sweating/night sweating
    □ Yes □ No  Recent unexplained weight loss

11. Please answer the following questions.
    □ Yes □ No  Do you smoke?
    □ Yes □ No  Any history of alcohol abuse?
    □ Yes □ No  Any other substance abuse?
    □ Yes □ No  Do you feel afraid to exercise?
    □ Yes □ No  Do you have insomnia?

12. Have you ever been diagnosed with any of the following?
    □ Yes □ No  Cancer - Type: ____________________
    □ Yes □ No  Immunosuppression
    □ Yes □ No  Osteoporosis
    □ Yes □ No  Rheumatoid or juvenile arthritis
    □ Yes □ No  Osteoarthritis
    □ Yes □ No  Recent infection
    □ Yes □ No  Bone fracture
    □ Yes □ No  Fibromyalgia
    □ Yes □ No  Headaches/migraines
    □ Yes □ No  Other chronic pain: Where? ______
    □ Yes □ No  Anxiety
    □ Yes □ No  Bipolar Disorder
    □ Yes □ No  Other: ________________________

***NEW PATIENTS ONLY***

13. Have you had any previous medical tests or treatments for your back pain?
    □ Yes (complete table below)  □ No (skip table)

<table>
<thead>
<tr>
<th>Tests</th>
<th>Where</th>
<th>When</th>
<th>Treatments</th>
<th>Where</th>
<th>When</th>
<th>Was this treatment helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ X-ray</td>
<td></td>
<td></td>
<td>□ Surgery</td>
<td></td>
<td></td>
<td>□ Yes  □ No</td>
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<tr>
<td>□ MRI</td>
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<td></td>
<td>□ Spine injection</td>
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<td>□ Yes  □ No</td>
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<td>□ CT scan</td>
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<td>□ Physical therapy/exercise</td>
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<td>□ Yes  □ No</td>
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<td>□ EMG (electromyelogram)</td>
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<td>□ Ice/heat</td>
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<td>□ Yes  □ No</td>
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<tr>
<td>□ Bone density exam</td>
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<td>□ Chiropractor</td>
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<td>□ Yes  □ No</td>
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<td>□ Other:</td>
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<td>□ Back brace</td>
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<td>□ Massage</td>
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<td>□ Yes  □ No</td>
</tr>
</tbody>
</table>

14. Have you talked with an attorney about the cause of your back pain? □ Yes  □ No