

## Lumbar/Cervical Spine Evaluation

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Describe Chief Complaint: \_\_\_\_\_  
\_\_\_\_\_

How long has pain or problem been present? \_\_\_\_\_

Do you have a history of back problems? \_\_\_\_\_

Is it related to a trauma, accident, or injury? When? \_\_\_\_\_

Briefly describe the trauma/injury: \_\_\_\_\_  
\_\_\_\_\_

Onset of condition: gradual rapid Since the event, are your symptoms: better worse same

Please check any of the following symptoms you have.

- \_\_\_\_\_ Pain that travels or radiates into limb Where: \_\_\_\_\_
- \_\_\_\_\_ Tingling/numbness in limb Where: \_\_\_\_\_
- \_\_\_\_\_ Weakness in limb Where: \_\_\_\_\_
- \_\_\_\_\_ Burning sensation in limb Where: \_\_\_\_\_

Rate pain intensity (0-10): \_\_\_\_\_ Constant or intermittent? \_\_\_\_\_ Frequency: \_\_\_\_\_

What makes it worse (positions/activities): \_\_\_\_\_

- |                        |   |   |
|------------------------|---|---|
| • Coughing or sneezing | Y | N |
| • Worse in AM          | Y | N |
| • Worse in PM          | Y | N |
| • Pain variable        | Y | N |

Have you had a change in

- |                             |   |   |
|-----------------------------|---|---|
| • Bowel or Bladder Function | Y | N |
| • Sleeping Habits Disturbed | Y | N |

What provides relief(positions/activities)? : \_\_\_\_\_

Treatment Hx.: \_\_\_\_\_

Medication Hx.: \_\_\_\_\_

Describe your Occupation: \_\_\_\_\_

\_\_\_\_\_ Any lost time? \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_