MESQUITE ORTHOPEDIC CLINIC

DATE: ______________________

NAME: ________________________________

1. What date (roughly at least) did your present pain start? ______________
2. How did it start?

a.	No accident	( )	e.	Hit in Back	( )
b.	Lifting	( )	f.	Auto accident	( )
c.	Twisting	( )	g.	Bending	( )
d.	Fall	( )	h.	Pulling	( )

3. Pain is worse in:

a.	Back	( )	e.	Neck	( )
b.	Back and Hip	( )	f.	Head	( )
c.	Down the leg(s)	( )	g.	Arm(s)	( )
d.	All of the above	( )	h.	None of the above	( )

4. How long have you been unable to work or do normal housework? _____________________

5. How long have you had any problems with back, neck, legs or arms? ___________________

6. My pain is: (Check the appropriate box.)

	Better	Worse	No Different
With cough or sneeze	_____	_____	________
Sitting in a straight chair	_____	_____	________
Sitting in a soft easy chair	_____	_____	________
Bending forward to brush teeth	_____	_____	________
When I wake in the morning	_____	_____	________
Middle of the night	_____	_____	________
Mid Day	_____	_____	________
Lying flat on back	_____	_____	________
Lying flat on stomach	_____	_____	________
On side with knees bent	_____	_____	________

7. Do you have to rest during the day because of your pain?

No	( )	Half of the day	( )
A little	( )	Over half of the day	( )

8. Have you been in a hospital for back, leg, neck or arm pain?

   Number of times ________________________ Give dates: ____________________________

9. Have you had myelograms (x-rays of spine with dye injections)?

   Number of times ________________________ Give dates: ___________________________

10. Have you had an EMG (nerve testing)? _______________ When? __________________________

11. Have you had neck or back surgery __________ When? _________________________________

12. Have you been in the hospital with other medical problems? _____________________________

    Number of times: ______________________ Describe: _________________________________

13. Do you exercise on a regular basis? ____

14. Please list current medications: ____

    ____

15. General medical problems:

Stomach problems, ulcer ect.	( )	Cancer	( )
Diabetes	( )	Heart	( )
Arthritis	( )	Epilepsy	( )
Gout	( )	Other	( )

16. List allergies: ____

17. Do other members of your family have significant back or neck trouble? ____________________

    Who? (Relationship) ____

18. What treatments have made your pain better? ____

19. What treatments have made your pain worse? ____

20. What is the most aggravating thing about your pain? _____________________________________

21. What brought you to this office? ____

22. Please add any other information you feel would be helpful: _______________________________

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Please complete pain drawing on next page.