

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.)

	<u>Better</u>	<u>Worse</u>	<u>No Different</u>
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: _____
- _____

Please complete pain drawing on next page.