HealthZone MD
FAMILY AND SPORTS MEDICINE WELLNESS CENTER

# Spine Form

Name: _____

Date: M M / D D / Y Y Y Y

## IDENTIFYING THE PAIN

Describe the mechanism of injury/problem

| | | | | | |
|---|---|---|---|---|---|
| Ankle | ❑ L | ❑ R | Calf | ❑ L | ❑ R |
| Cervical Spine | ❑ L | ❑ R | Chest/Sternum | ❑ L | ❑ R |
| Coccyx | ❑ L | ❑ R | Elbow | ❑ L | ❑ R |
| Hip | ❑ L | ❑ R | Lower Back | ❑ L | ❑ R |
| Ribs | ❑ L | ❑ R | Sacrum | ❑ L | ❑ R |
| Upper Back | ❑ L | ❑ R | Other: _____ | | |

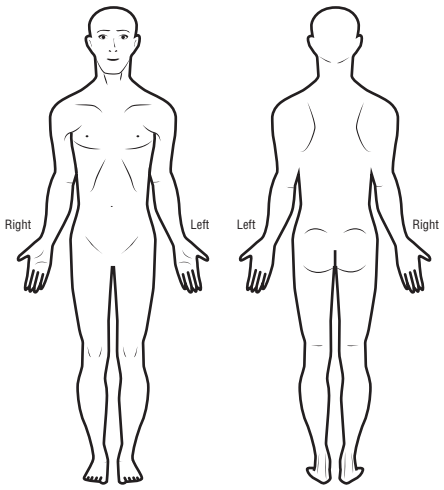
❑ Bilateral (Both Sides) ❑ Anterior (Front) ❑ Posterior (Back)
❑ Medial (Inner) ❑ Lateral (Outer)

Please indicate the problem area with the following:

XXXX Sharp Pain

//// Dull Ache

---- Numbness or Tingling




## CONTEXT

❑ Cannot Identify ❑ Fall
❑ Bending ❑ Lifting
❑ Twisting ❑ Sports Injury
❑ Work Injury ❑ Car Accident
❑ Assault ❑ Overuse
❑ Laceration ❑ Heard a Pop
❑ Other: _____

## SEVERITY

❑ No Pain ❑ Mild ❑ Moderate ❑ Severe

Pain Level(circle one): NONE 0 1 2 3 4 5 6 7 8 9 EXTREME 10

## ASSOCIATED SYMPTOMS

❑ Weakness ❑ Numbness
❑ Tingling ❑ Swelling
❑ Redness ❑ Warmth
❑ Bruising ❑ Catching/Locking
❑ Popping/Clicking ❑ Buckling
❑ Grinding ❑ Instability
❑ Drainage ❑ Fever
❑ Weight Loss ❑ Radiating Pain
❑ Change in Bowel/Bladder Habits
❑ Other: _____

## ALLEVIATING FACTORS

❑ Nothing Helps ❑ Ice
❑ Rest ❑ Elevation
❑ Exercise ❑ Stretching
❑ PT/OT ❑ NSAIDs
❑ Orthotics ❑ Brace
❑ Previous Surgery ❑ Sling
❑ Limited Weightbearing
❑ Chiropractic Care ❑ Narcotics
❑ Epidural Steroid Injection
❑ Over-the-counter Medication
❑ Cortisone Injection
❑ Viscosupplementation Injection
❑ Other: _____

## AGGREVATING FACTORS

❑ Cannot Identify ❑ Lifting
❑ Carrying ❑ Twisting
❑ Pushing/Pulling ❑ Gripping
❑ Grasping ❑ Squeezing
❑ Throwing ❑ Range of Motion
❑ Weightbearing ❑ Exercise
❑ Previous Surgery ❑ Computer Use
❑ Changing Clothes ❑ Getting Out of Bed
❑ Going from Sit to Stand
❑ Morning ❑ Daytime
❑ Nighttime ❑ Cold Weather
❑ Damp Weather ❑ Driving
❑ Other: _____

## HISTORY

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Arthritis/Musculoskeletal Problems | ❑ Self | ❑ Family | Congenital Abnormalities | ❑ Self | ❑ Family | Cancer | ❑ Self | ❑ Family |
| Cerebral/Seizure Problems | ❑ Self | ❑ Family | Heart Problems | ❑ Self | ❑ Family | Diabetes | ❑ Self | ❑ Family |
| Renal/Urinary Tract Problems | ❑ Self | ❑ Family | Psychiatric Problems | ❑ Self | ❑ Family | | | |

## PRIOR RELATED INCIDENCES

| | | |
|---|---|---|
| Prior Treatment ❑ None ❑ Yes | Prior Diagnosis & Treatment | Treatment Date M M / D D / Y Y Y Y |
| Prior Related Surgery ❑ None ❑ Yes | Procedure Type | Procedure Date M M / D D / Y Y Y Y |
| Prior Imaging (Past 3 Months) ❑ None ❑ Yes | Imaging Type ❑ X-Ray ❑ MRI ❑ Other: _____ | Imaging Date M M / D D / Y Y Y Y |
| Previous Injections ❑ None ❑ Yes | Injection Type | Injection Date M M / D D / Y Y Y Y |
| ❑ Injections Did Not Help ❑ Injections Helped a Little ❑ Injections Helped Temporarily ❑ Injections Helped Significantly | | |
| Previous Therapy ❑ None ❑ Yes | Therapy Type | Therapy Date M M / D D / Y Y Y Y |
| ❑ Therapy Did Not Help ❑ Therapy Helped a Little ❑ Therapy Helped Temporarily ❑ Therapy Helped Significantly | | |

Reset
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