

Spine HPI

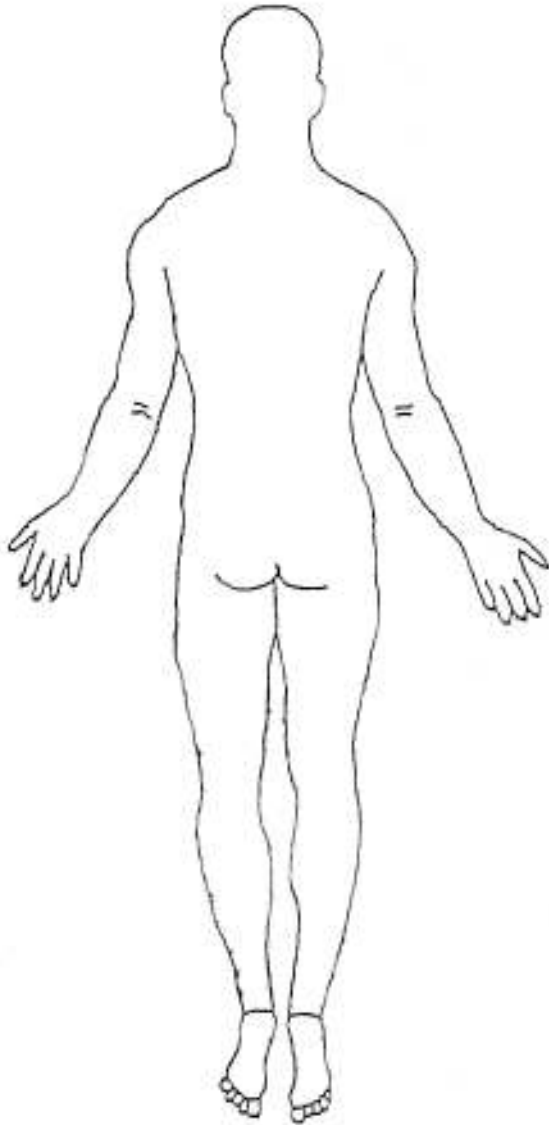
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Quality:

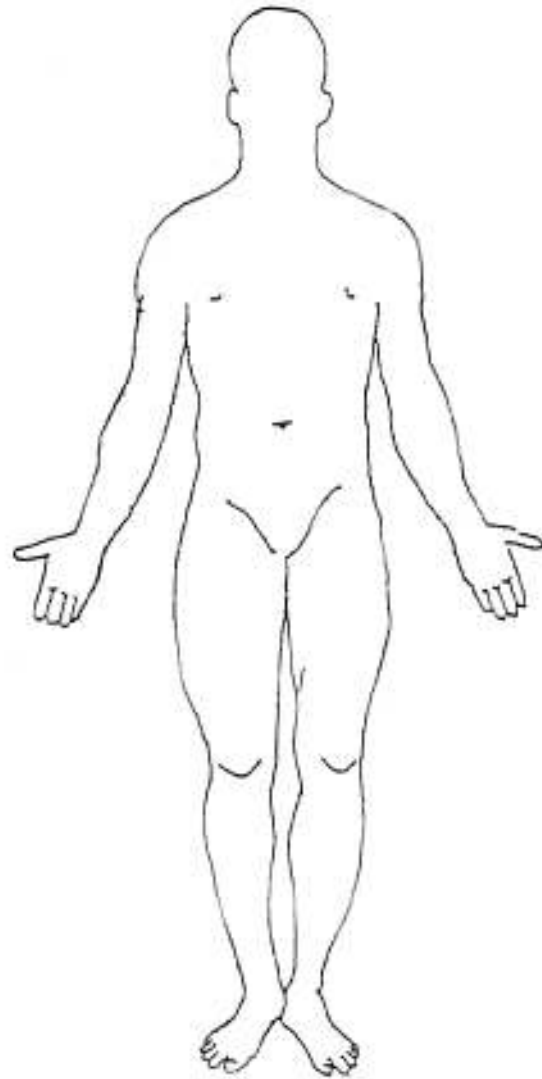
Mark the areas on the diagram where you feel the following sensations on your body using the symbols.

Ache                  Numbness                  Pins & Needles                  Burning                  Stabbing                  Tingling  
+++++                  =====                  ooooooo                  xxxxx                  //////////////                  \*\*\*\*\*

Please use a ^^^^ for where the pain first started.



Back



Front

For Office Use Only

Date	Age	Height	Weight	Date	Age	Height	Weight

**Spine HPI**

**Patient DOB:** \_\_\_\_\_

**Location:**

What body part are you being seen for today? \_\_\_\_\_

My pain is: \_\_\_\_\_% is in my back/neck  
+ \_\_\_\_\_% is in my legs/arms  
= 100%

**Severity:**

On a scale of 0-10 (0= no pain, 10=intolerable) my pain is a: 0 1 2 3 4 5 6 7 8 9 10

**Duration:**

On what date (or approximate date) did your pain/symptoms begin? \_\_\_\_\_

**Timing:**

How often do your symptoms occur?  daily  weekly  monthly  morning  evening  after activity  
 intermittent  constant  other \_\_\_\_\_

What time of day are your symptoms the worst? \_\_\_\_\_ The best? \_\_\_\_\_

**Context:**

Describe how this injury or problem first occurred: \_\_\_\_\_

Was this a result of an:  Motor vehicle accident?  Work injury?  Other \_\_\_\_\_

**Modifying Factors:**

What aggravates (increases) your symptoms?  walking  standing  driving  lifting  pushing/pulling  
 head rotation  twisting or turning  activities for an extended period of time  sports: \_\_\_\_\_  
 other: \_\_\_\_\_

What relieves (decreases) your symptoms?  ice  heat  rest  elevation  immobilization  stretching  
 other: \_\_\_\_\_

**Associated signs and symptoms:**

What other symptoms are associated with your pain?  none  dizziness  headache  weakness  
 muscle spasms  tingling  numbness  other: \_\_\_\_\_

\*How far can you walk before you need to rest? \_\_\_\_\_

\*Have you been seen by anyone else (ER, Family practice) regarding this problem?  No  Yes, Name & Specialty  
\_\_\_\_\_

\*Please list **any previous tests** (MRI, x-rays, CT scan, etc) you have had for this problem (include dates & where performed): \_\_\_\_\_

\*Please list **any previous treatments** (injections, PT, bracing, surgery, etc.) you have had for this problem and **how you responded** to treatments (include dates & where performed): \_\_\_\_\_

\*What **previous problems** have you with your **back, neck, legs or arms**? Please describe (include dates):  
\_\_\_\_\_