

Spine HPI

Patient Name: _____ DOB: _____ Today's Date: _____

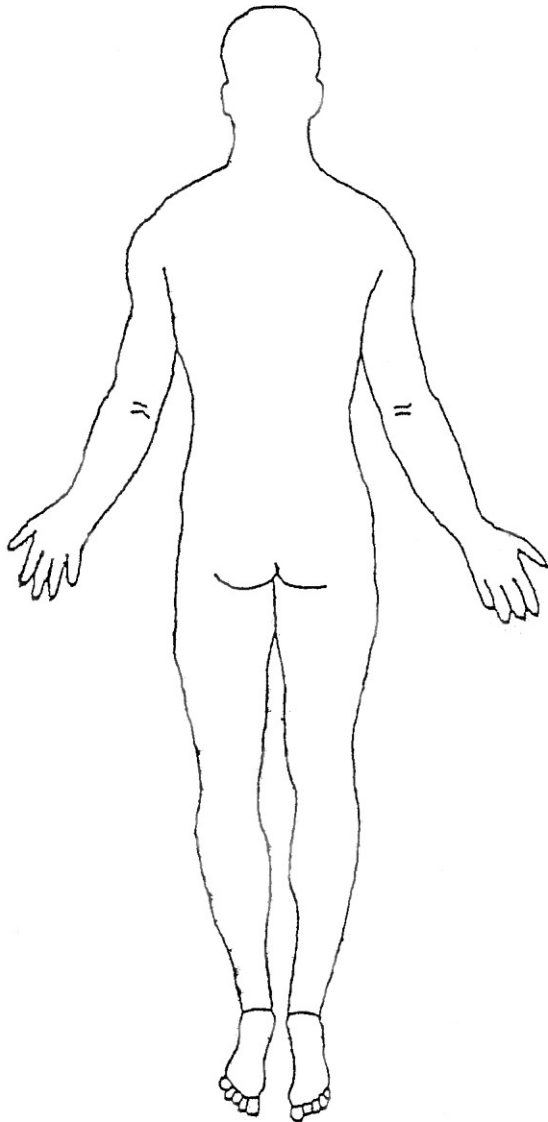
Primary Care Physician: _____ Referring Physician: _____

Quality:

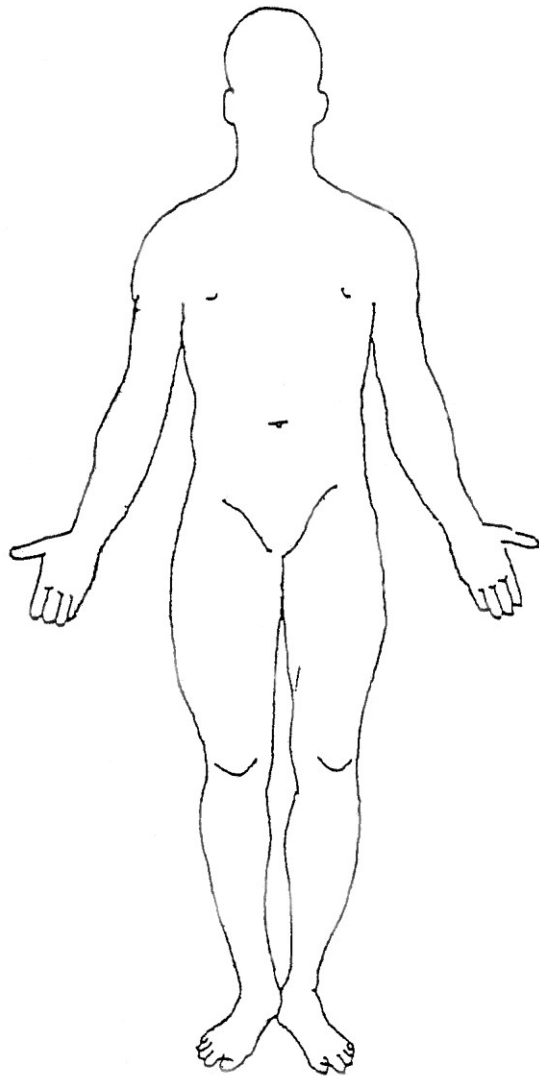
Mark the areas on the diagram where you feel the following sensations on your body using the symbols below

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

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 a: 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 had with your **back, neck, legs or arms**? Please describe (include dates): _____