erlanger Health System
We practice what we teach.

Spinal Worksheet

Name: ____ **Date:** ________________

Location of Pain: (circle) Back - Upper Mid Low

Neck

Legs - Right Left Both

Arms - Right Left Both

Severity of Pain: on a scale 1 – 10 (1 being best & 10 being worst) __________

Quality/Type: ☐ Burning ☐ Aching ☐ Electrical Other: ________________

Timing: When did it start? ____

Has it ever happened before? ______________________________

Progression: Has it gotten - ☐ Worse ☐ Stayed the Same

Neurological Symptoms: ☐ Numbness ☐ Tingling ☐ Weakness

Where: ____

Associated Symptoms: ☐ Difficulty Walking ☐ Loss of Bowel / Bladder Control

☐ Sexual Dysfunction

Any Previous Treatments:

- **Medications**: ____

  Date Started: ________ How Long: ________ Did it Help? Yes ☐ No ☐ Somewhat ☐

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- **Physical Therapy**- Yes ☐ No ☐ Date Started:________ How Long: ________

  Provided by: ______________________________ Did it Help? Yes ☐ No ☐ Somewhat ☐

- **Chiropractic Visits**- Yes ☐ No ☐ Date Started:________ How Long: ________

  Provided by: ______________________________ Did it Help? Yes ☐ No ☐ Somewhat ☐

- **Injections**- Yes ☐ No ☐ Date Started:________ How Long: ________

  Provided by: ______________________________ Did it Help? Yes ☐ No ☐ Somewhat ☐

Any additional information: ____

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