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 □

- **Medications:** ___________________________________________________________________

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

- **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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revised 4-21-15