

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: _____