erlanger Health System

UT Erlanger Neurosurgery & Spine

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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  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 8.4.20