Chattanooga 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 □
  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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