

PAIN SHEET

SPINE EVALUATION

LAST NAME	FIRST	MIDDLE INIT.	AGE	TODAY'S DATE

1. What was your chief complaint when you visited your doctor? _____

2. What do you think caused the problem? _____

3. What does your doctor think is causing your back pain? _____

4. Describe your pain (e.g., burning, sharp, etc.) _____

5. Does the pain go down your arm? _____ Your Leg? _____ In the back or front? _____
Left, right or both? _____
6. a. Does anything make the pain worse (e.g. standing, sitting, lying down, etc.)? _____

b. Does anything make it better? _____
7. Do you have any numbness? _____ Where? _____
8. Do you have any weakness? _____ Where? _____
9. Have you had any bowel or bladder changes? _____ Describe: _____

10. Have you had surgery to the area being scanned today? _____
When? _____
What was done? _____
11. Are you taking any medicines? _____
What kind? _____
12. Do you have any other medical conditions? _____

13. Do you exercise regularly? _____ What type? _____
14. Describe your general health: _____

