LUMBAR FORM: **Patient Name:** ______________________ **Today's Date:** __________

Back Pain? YES NO C R L ______________________

– Into buttock?	YES	NO	RIGHT	LEFT
– Into hip?	YES	NO	RIGHT	LEFT
– Into groin?	YES	NO	RIGHT	LEFT
– Into thigh?	YES	NO	RIGHT–A P L	LEFT–A P L
– Into knee?	YES	NO	RIGHT	LEFT
– Into lower leg?	YES	NO	RIGHT–A P L	LEFT–A P L
– Into ankle?	YES	NO	RIGHT	LEFT
– Into foot?	YES	NO	RIGHT	LEFT
– Into toes?	YES	NO	RIGHT	LEFT

Numbness / Tingling? YES NO Notes: ______________________

Is it constant? YES NO Notes: ______________________

How long has it been like this? Weeks: ______ Months: ______ Years: ______ Worse in Last: ______

Overall how long? Weeks: ________ Months: ________ Years: ________

Have you had any problem like this in the past? YES NO Notes: ______________________

Has it gotten worse over the years? YES NO Notes: ______________________

Is the pain: ❑ Burning ❑ Ache ❑ Sharp ❑ Dull ❑ Deep ❑ Throbbing ______________________

1 to 10 when pain is at its worst: 1 2 3 4 5 6 7 8 9 10

Did the pain come on: ❑ Gradually ❑ Suddenly ______________________

Injury: ______________________

Do you smoke? YES NO If yes, how much? ______________________

What aggravates your pain?

❑ Bending ❑ Lifting ❑ Twisting ❑ Sitting ❑ Standing: ________ ❑ Walking: ________

❑ Laying down ❑ Getting in / out of vehicle ❑ Other: ______________________

Do any of these relieve the pain?

❑ Heat ❑ Ice ❑ Stretching ❑ Pain Meds ❑ Rest

❑ Nothing ❑ Other: ______________________

LUMBAR FORM: **Patient Name:**________________ **Today's Date:**________

Is it worse in the: ❑ Morning ❑ Afternoon ❑ Evening ❑ Night / Sleep ❑ Increase w / Activities ❑ All Same

Have you been told exactly what condition(s) you have? ________________

Have you tried:			**Did it:**		
Medications:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Physical Therapy:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Exercise / Stretching:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Chiropractic:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Epidurals:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Rhizotomy:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Surgery:	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief
Other: ________	YES	NO	❑ Aggravate	❑ Temp Relief	❑ No Relief

Have you been told you need an epidural or surgery yet? YES NO By whom?________________

How do you feel about spinal surgery as a possibility? ________________

Any other major health challenges? ________________

Have you had any...

- ❑ Recent spine fracture? YES NO Notes:________________
- ❑ Dx w/Abdominal Aneurism? YES NO Notes: ________________
- ❑ Bone Cancer? YES NO Notes:________________
- ❑ Kidney infection? YES NO Notes:________________
- ❑ Urinary Tract infection? YES NO Notes:________________
- ❑ Bone infection / disease / disorder? YES NO Notes: ________________
- ❑ Night Cramping? YES NO CALVES FEET TOES RIGHT LEFT
- ❑ Swelling? YES NO LEGS ANKLES FEET RIGHT LEFT

Any muscle weakness yet? YES NO Notes: ________________

Any muscle atrophy? YES NO Notes: ________________

How is this affecting your life? ________________

How serious do you consider this? ________________

What do you think will happen if left untreated? ________________

Notes:________________

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