

Lakeshore Bone & Joint Institute
PATIENT HISTORY FORM FOR BACK AND NECK PAIN

This form will greatly aid the physician in your health care. We appreciate your cooperation in providing this information.

Patient Name _____ Age _____ Date _____

1. On what approximate date did your present pain start? _____

2. How long have you been unable to perform normal activity? _____

3. Did your pain start gradually or suddenly? _____

Is it the result of an accident? Yes No

Where did the pain start? (ie. neck, back, etc.) _____

4. Please describe how your pain started: _____

5. Have you changed jobs or stopped work because of this pain? Yes No

6. How far can you walk before you have to rest? _____

7. What previous problems have you had with your back, neck, legs or arms? _____

8. Have you had myelograms (x-rays of the spine with dye injection), MRI's or CT scans? Yes No

9. Do you have an attorney helping you? Yes No

10. Are you under any pressure at home? Yes No

... at work? Yes No

11. What treatments have made your pain better? _____

12. What is the most aggravating thing about your pain? _____

13. On a scale from one to ten, how bad is your pain?

No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

14. When, during the day is the pain the worst? _____

... the best? _____

15. In percentages, how much of the pain is in your back/neck and how much is in your legs/arms?

_____ % of the pain is in my back/neck

_____ % of the pain is in my legs/arms

= _____ 100%

over 

Patient Name _____

16. On the following diagram, mark the areas on your body where you feel the following sensations
(Mark the diagram using the following symbols):

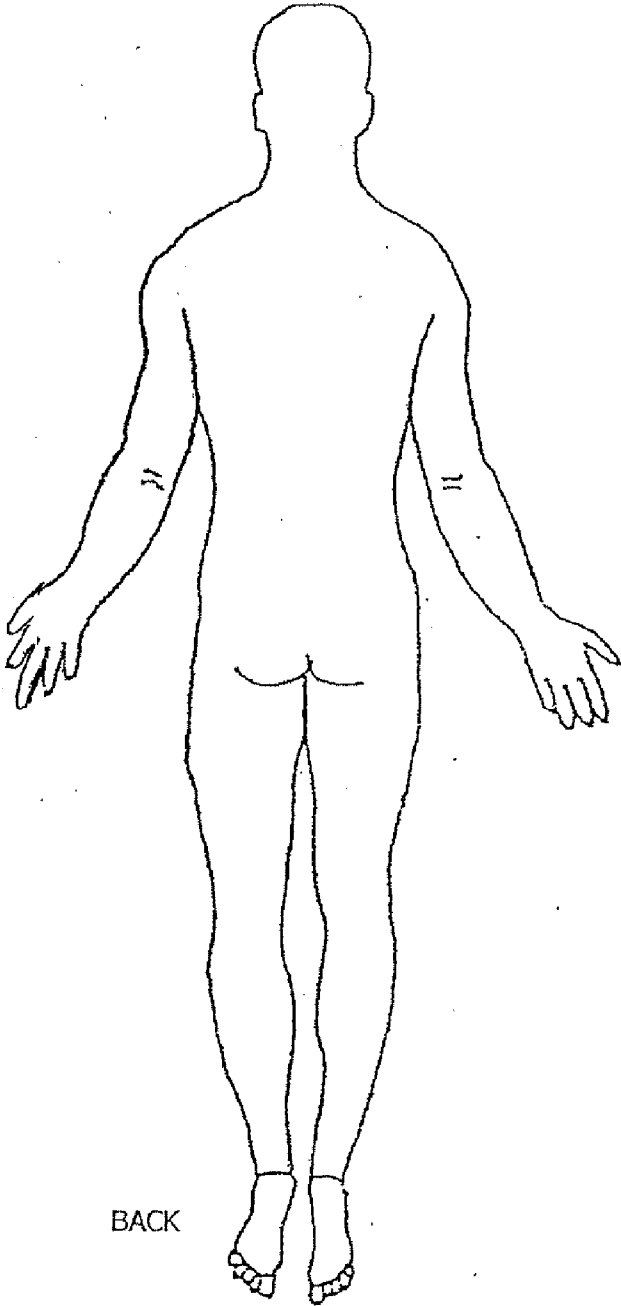
Ache
++++

Numbness
====

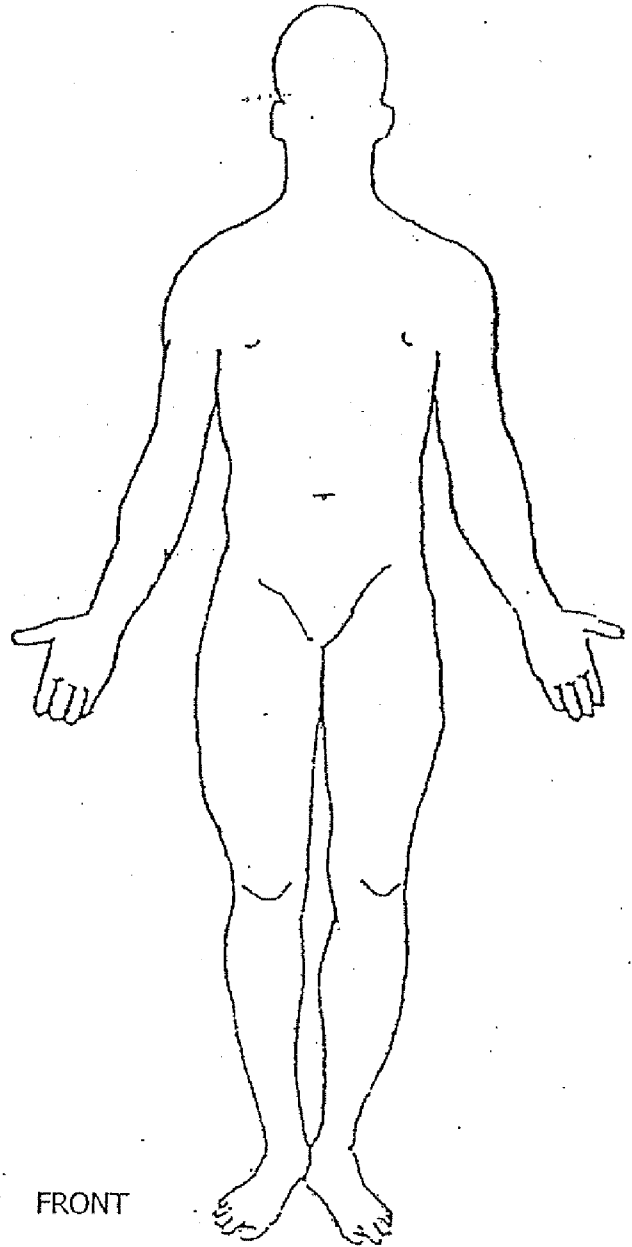
Pins and Needles
oooo

Burning
XXXX

Stabbing
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BACK



FRONT

Thank you for providing us with this information

For Office Use Only

Date	Age	Height	Weight	Date	Age	Height	Weight