

Advanced Spine Care of Texas

Texas Orthopaedic Surgical Associates

Spine Evaluation Form

Name: _____
Last First MI

Dominant Hand: R L

Chief Complaint: Which part of your spine is your main concern today?
 Low back/Legs Neck/Arms Thoracic/ upper back

Onset of spine problem:
When did your current problem/symptoms begin? _____

Describe onset and preceding events: _____

Have your symptoms changed since onset? _____
Have you had prior episodes of this condition? _____

Is your problem the result of an on-the-job injury? Yes No
Estimated Date of Injury: _____

Pain Diagram:

Draw the exact **location and pattern** of your symptoms on your body where you **now feel** your **typical symptoms**. Include all affected areas. Use the appropriate symbols indicated below.

FRONT

BACK

SYMBOLS:

ACHE

>>>>

>>>>

NUMBNESS

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STABBING

PAIN

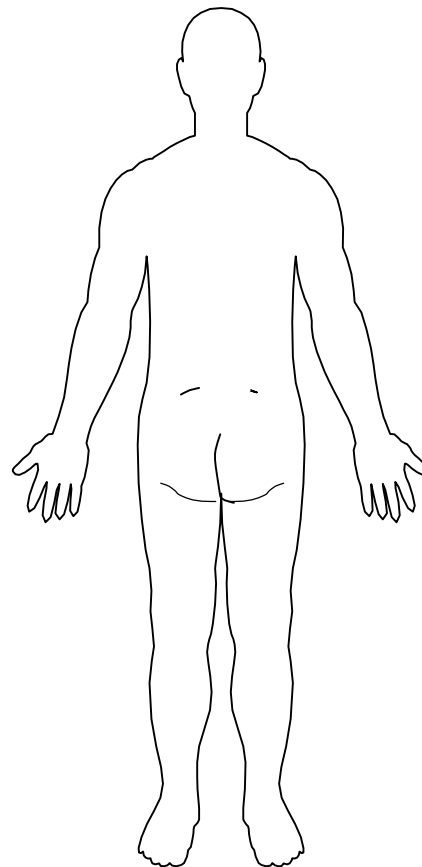
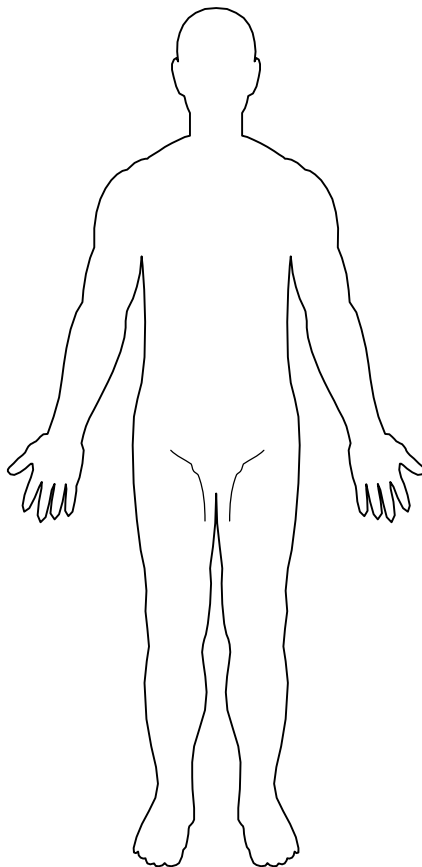
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PINS & NEEDLES

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Pain Severity

If 10 is the worst pain imaginable and 0 is no pain at all, please note your pain over the last **TWO WEEKS**:

- a) Please rate your **AVERAGE** amount of back/ neck pain: 0 1 2 3 4 5 6 7 8 9 10
 b) Please rate your **AVERAGE** amount of leg/ arm pain: 0 1 2 3 4 5 6 7 8 9 10

What does each of the following activities do to your pain?

	No Change	Relieves Pain	Increases Pain	After how Long?
Sitting				
Walking				
Standing				
Lying Down				
Bending Forward				
Bending Backward				
Lifting				
Coughing/Sneezing				
Changing Positions				

Which other activities, motions, or positions affect your symptoms? _____

What do you do to relieve your pain? _____

Check all those that apply to you:

- Bladder Function: Normal Loss of control or accidents Difficulty starting urination
 Sense of urgency
 Bowel function: Normal Loss of control or accidents
 Problems with sexual function?: No Yes
 Loss of sensation around the groin, genitals or buttocks? No Yes
 Weakness of a leg/foot? No Yes (Right Left)
 Weakness of arm/hand? No Yes (Right Left)
 Does your pain hurt only at night or awaken you at night? No Yes
 Does your pain interfere with your sleep? No Yes

Previous Treatment, Consultation, or Tests for this spine problem:

	Helped	Effect of Treatment Made things worse	No difference
<input type="checkbox"/> Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spinal injections, epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Regular Xrays MRI Myelogram CT Scan

Bone Scan EMG/NCV

Physicians seen: (Name, type of specialty, approx. dates) _____

Medications tried (list) _____

Function:

Pain Intensity (Mark only one)

0 I can tolerate the pain I have without having to use pain killers

1 The pain is bad but I manage without taking pain killers

2 Pain killers give complete relief from pain

3 Pain killers give moderate relief from pain

4 Pain killers give very little relief from pain
 5 Pain killers have no effect on the pain, I do not use them.

Personal Care (Washing, Dressing, etc.) (Mark only one)

0 I can look after myself normally without it causing extra pain.
 1 I can look after myself normally but it causes extra pain.
 2 It is painful to look after myself and I am slow and careful
 3 I need some help but manage most of my personal care.
 4 I need help everyday in most aspects of self care.
 5 I do not get dressed, wash with difficulty and stay in bed.

Lifting (Mark only one)

0 I can lift heavy weights without extra pain.
 1 I can lift heavy weights but it gives extra pain.
 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
 3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
 4 I can lift only very light weights.
 5 I cannot lift or carry anything at all.

Walking (Mark only one)

0 Pain does not prevent me from walking any distance.
 1 Pain prevents me walking more than 1 mile.
 2 Pain prevents me walking more than ½ mile.
 3 Pain prevents me walking more than ¼ mile.
 4 I can only walk using a stick or crutches.
 5 I am in bed most of the time and have to crawl to the toilet.

Sitting (Mark only one)

0 I can sit in any chair as long as I like.
 1 I can only sit in my favorite chair as long as I like.
 2 Pain prevents me from sitting more than one hour.
 3 Pain prevents me from sitting more than thirty minutes.
 4 Pain prevents me from sitting more than ten minutes.
 5 Pain prevents me from sitting at all.

SCORE _____

Standing (Mark only one)

0 I can stand as long as I want without extra pain.

Name: _____ **Date:** _____ **Acct #:** _____

1 I can stand as long as I want but it gives extra pain.
 2 Pain prevents me from standing more than one hour.
 3 Pain prevents me from standing more than thirty minutes.
 4 Pain prevents me from standing more than ten minutes.
 5 Pain prevents me from standing at all.

Sleeping (Mark only one)

0 Pain does not prevent me from sleeping well.
 1 I can sleep well only by using tablets.
 2 Even when I take tablets I have less than six hours sleep.
 3 Even when I take tablets I have less than four hours sleep.
 4 Even when I take tablets I have less than two hours sleep.
 5 Pain prevents me from sleeping at all.

Employment/Homemaking (Mark only one)

0 My normal homemaking/job activities do not cause pain.
 1 My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
 2 I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
 3 Pain prevents me from doing anything but light duties.
 4 Pain prevents me from doing even light duties.
 5 Pain prevents me from performing any job or homemaking chores.

Social Life (Mark only one)

0 My social life is normal and gives me no extra pain.
 1 My social life is normal but increases the degree of pain.
 2 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
 3 Pain has restricted my social life and I do not go out as often.
 4 Pain has restricted my social life to home.
 5 I have no social life because of pain.

Traveling (Mark only one)

0 I can travel anywhere without extra pain.
 1 I can travel anywhere but It gives extra pain.
 2 Pain is bad but I manage journeys over two hours.
 3 Pain restricts me to journeys less than one hour.
 4 Pain restricts me to short journeys under thirty minutes.
 5 Pain prevents me from traveling except to the doctor or hospital.

Previous Spine Surgeries:

Type	Date	Surgeon	Pain better?

For younger patients with scoliosis:

Family history of scoliosis? _____
 Family history of genetic disorders? _____
 Growth over past year in inches? _____

For girls: have you begun periods yet and at what age? _____

Family Health History: Have your blood relatives had the following? If yes, explain which relative and type of condition.)

Multiple Sclerosis ☐ Yes _____

When was your last Physical Exam? _____ By whom: _____
Primary Care Physician: _____

Social History:

Education: How much have you completed?

☐ Less than high school ☐ HS diploma/GED ☐ Vocational school ☐ Some college
☐ College degree _____ ☐ Post graduate degree(s) _____

Stress: Have you had a stress or change in a significant relationship in the last year? Yes ☐ No ☐
If yes, please explain: _____

Patient Signature _____ **Date** _____

Physician's Signature _____ **Date** _____