Texas Health Physicians Group®
North Texas Neck & Back

Patient Name:_____ DOB ____/____/_____ Original Referring Physician: _____

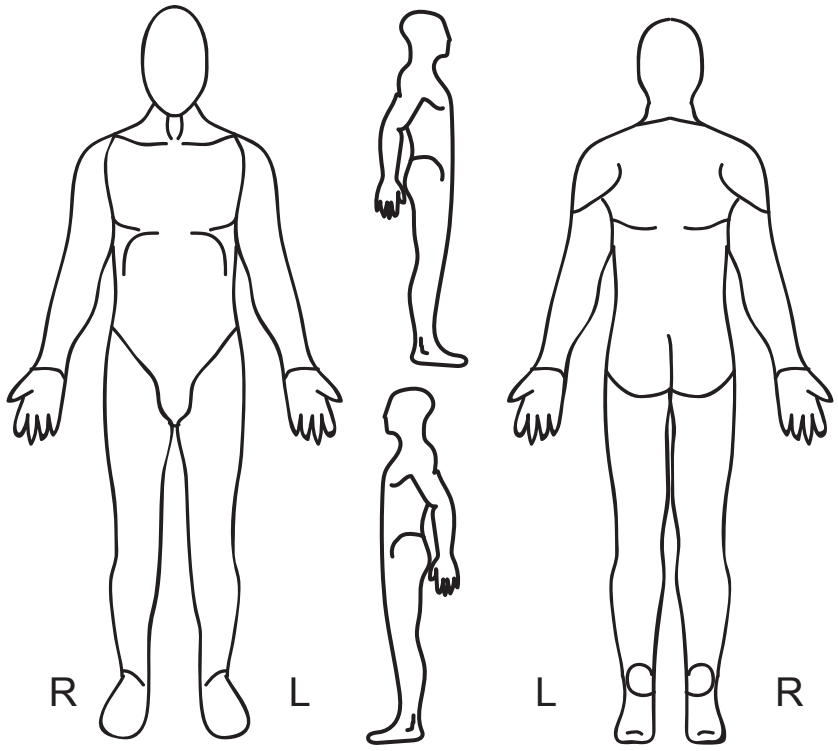
PAIN DIAGRAM Current PCP: _____

Is your condition the result of a: Work injury? □ YES □ NO Auto accident? □ YES □ NO

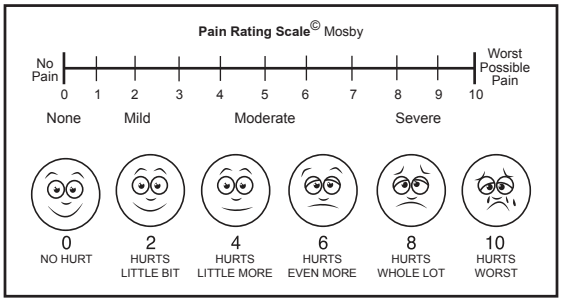
Date of Injury: _____/_____/_____

Please mark the areas of discomfort on the diagram below using the appropriate symbols below:

Pain or burning: **x x x x x** Numbness: **o o o o o** Pins and Needles: **= = = = =**



Grade your overall pain



Please place an X on the above hash mark that most accurately describes your overall degree of pain *now*.

Please indicate in table below the percentage of pain you currently feel in your neck, arm, back and legs. Example (0%, 25%, 75%, 100%)

For patients with neck and arm pain

Neck Pain _____ %

Arm Pain _____ %

Total Pain 100%

For patients with back and leg pain

Back Pain _____%

Leg Pain _____%

Total Pain 100%

Patient Name:_____ DOB ____/____/_____

HISTORY: (Check all that apply)

Chief Complaint: □ Back pain Leg: □ Pain □ Numbness □ Weakness □ Other Body Part (specify) _____

□ Neck pain Arm: □ Pain □ Numbness □ Weakness □ Balance Deficit □ Gait Instability

When did your present pain begin? _____

How did your pain start? _____

Date of Injury? _____ OR: □ Less than 6 months □ More than 6 months □ Greater than 1 year

My pain is: □ Worsening □ Improving □ Unchanged since it started

For patients with NECK or ARM pain, numbness or weakness:

Neck Pain	□ R	□ L	Arm Pain	□ R	□ L		
Numbness	□ R	□ L	Weakness	□ R	□ L		

For patients with BACK or LEG pain, numbness or weakness:

Back Pain	□ R	□ L	Leg Pain	□ R	□ L
Numbness	□ R	□ L	Weakness	□ R	□ L

Do you have difficulty picking up small objects like coins or buttoning buttons? □ YES □ NO

Do you have problems with balance or frequent tripping? □ YES □ NO

Worst position for pain is: □ Sitting □ Standing □ Walking

How many minutes can you stand/walk before you need to rest? □ 0-10 □ 15-30 □ 30-60 □ 60+

Lying down: □ Eases the pain □ Does not ease the pain □ Sometimes eases the pain

Bending forward: □ Increases the pain □ Decreases the pain □ Does not affect the pain

There is: □ No loss of bowel or bladder control (incontinence) □ Loss of bowel and bladder control since: _____

Other activities/positions that increase pain: _____

Other activities/positions that reduce pain: _____

I have: □ Not missed any work because of this problem □ How much work have you missed: _____

Treatment has included: (Check all that apply)

□ NO medication, physical therapy, chiropractic manipulations, injections, or bracing

□ Anti-inflammatory medication

□ Muscle relaxants

□ Narcotic pain medication

□ Physical Therapy

□ Chiropractic manipulation

□ Traction

□ Acupuncture

□ In-office injections without X-ray

□ Epidural steroid injections

□ Facet injections

□ Sacroiliac (SI) Injections

□ Braces

□ Other: _____

Previous doctors seen for this problem:

□ **NONE**

Doctor_____ Specialty_____ City_____

Doctor_____ Specialty_____ City_____

Treatment_____

_____

Patient Name:_____ DOB ____/____/_____

PREVIOUS IMAGING STUDIES: (Check all that apply)

□ **NONE**

□ X-Rays □ CT Scan □ MRI □ Myelogram □ EMG □ Bone Scan Results □ DEXA (bone density):_____

PAST MEDICAL HISTORY: (Check all that apply)

□ **None apply**

□ AIDS/HIV	□ Blood clot in leg/lung	□ Hepatitis	□ Migraines	□ Stomach Ulcers
□ Alcoholism	□ Bone fracture	□ High blood pressure	□ Osteoarthritis	□ Thyroid disease
□ Anemia	□ Cancer	□ Kidney failure	□ Osteoporosis	□ Tuberculosis
□ Anesthesia problems	□ Diabetes	□ Kidney stones	□ Rheumatoid arthritis	□ Wound history
□ Ankylosing spondylitis	□ Glaucoma	□ Liver disease	□ Seizures	
□ Asthma	□ GOUT	□ Lung disease	□ Serious injury (explain)	
□ Bleeding disorders	□ Heart attack	□ Mental illness	□ Stroke	

□ Other:_____

PAST SURGICAL HISTORY: (Check all that apply)

□ **None apply**

□ Abdominal	□ Heart Stent	□ Pacemaker
□ Appendectomy	□ Hysterectomy	□ Tonsillectomy
□ Back	□ Joint Replacement	□ Vascular
□ Cholecystectomy(Gallbladder)	□ Mastectomy	□ Other: _____
□ Heart	□ Neck	

MEDICATIONS

List all PAIN medications and dosages taken for your *current* problem:

□ **NONE**

Medication _____ Dosage_____

Medication _____ Dosage_____

Medication _____ Dosage_____

Please list all *current* medications or provide list:

□ **NONE**

Medication _____ Dosage_____

Medication _____ Dosage_____

Medication _____ Dosage_____

ALLERGIES

Please list any known allergies to food or medication and their reactions:

_____

_____

_____

FAMILY HISTORY: (Check all that apply)

□ **None apply**

□ Stroke	□ Alcoholism	□ Kidney trouble or stones	□ Seizures	□ Bleeding disorders
□ Arthritis	□ Heart trouble	□ Cancer	□ Diabetes	□ Anesthesia problems
□ Gout	□ Mental illness	□ High blood pressure	□ Spine problems	□ Other: _____

SOCIAL HISTORY: (Check all that apply)

Work Status: □ Homemaker □ Retired □ Disabled □ On leave □ Unemployed □ Employed

Occupation: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

I live: □ Alone □ With: _____

Do you smoke? □ Yes □ No _____ packs/day for _____ years □ Quit How long ago? _____

Drink alcohol? □ Daily □ 1-2 x/week □ 1-2 x/month □ Never □ Alcoholic □ Recovering alcoholic

Illicit drug use: □ Never □ Currently □ In the past

Patient Name:_____ DOB ____/____/_____

Review of Systems

Are you currently or have had problems with: * Please explain and describe all YES answers below

Hematological / Bleeding problems □ Yes □ No Describe: _____
Reproductive / Sexual problems □ Yes □ No Describe: _____
Unexplained weight loss: □ Yes □ No Describe: _____
Skin: □ Yes □ No Describe: _____
Ear, Nose, Throat: □ Yes □ No Describe: _____
Stomach / Digestion: □ Yes □ No Describe: _____
Bladder / Bowel problems: □ Yes □ No Describe: _____
Musculoskeletal: □ Yes □ No Describe: _____
Neurological: □ Yes □ No Describe: _____
Psychiatric problems: □ Yes □ No Describe: _____
Fever / Chills: □ Yes □ No Describe: _____
Night sweats: □ Yes □ No Describe: _____
Night pain / Pain at rest: □ Yes □ No Describe: _____

Patient Name:_____ DOB ____/____/_____

Office use only:

Vitals:

Age: Ht: Wt:

B/P: Pulse: Temp: BMI:

General:

Gait: _____

Assistive Devices:

□ Cane □ Walker □ Rollator

Spinal ROM:

Cervical: _____

Lumbar: _____

Strength:

UE: D_____ B_____ T_____ WE_____ WF_____ FF_____

LE: HF_____ Q_____ AT_____ GS_____ EHL_____

Sensory: □ Normal □ Abnormal

UE: C5 C6 C7 C8 T1 Non-derm

LE: L1 L2 L3 L4 L5 S1 Non-derm

Reflexes:

UE: 1+ 2+ BRISK ABSENT

LE: 1+ 2+ BRISK ABSENT

Pathological:

□ Clonus □ Babinski's □ Hoffman's □ SLR

Vascular:

□ Popliteal □ DP □ Post Tib