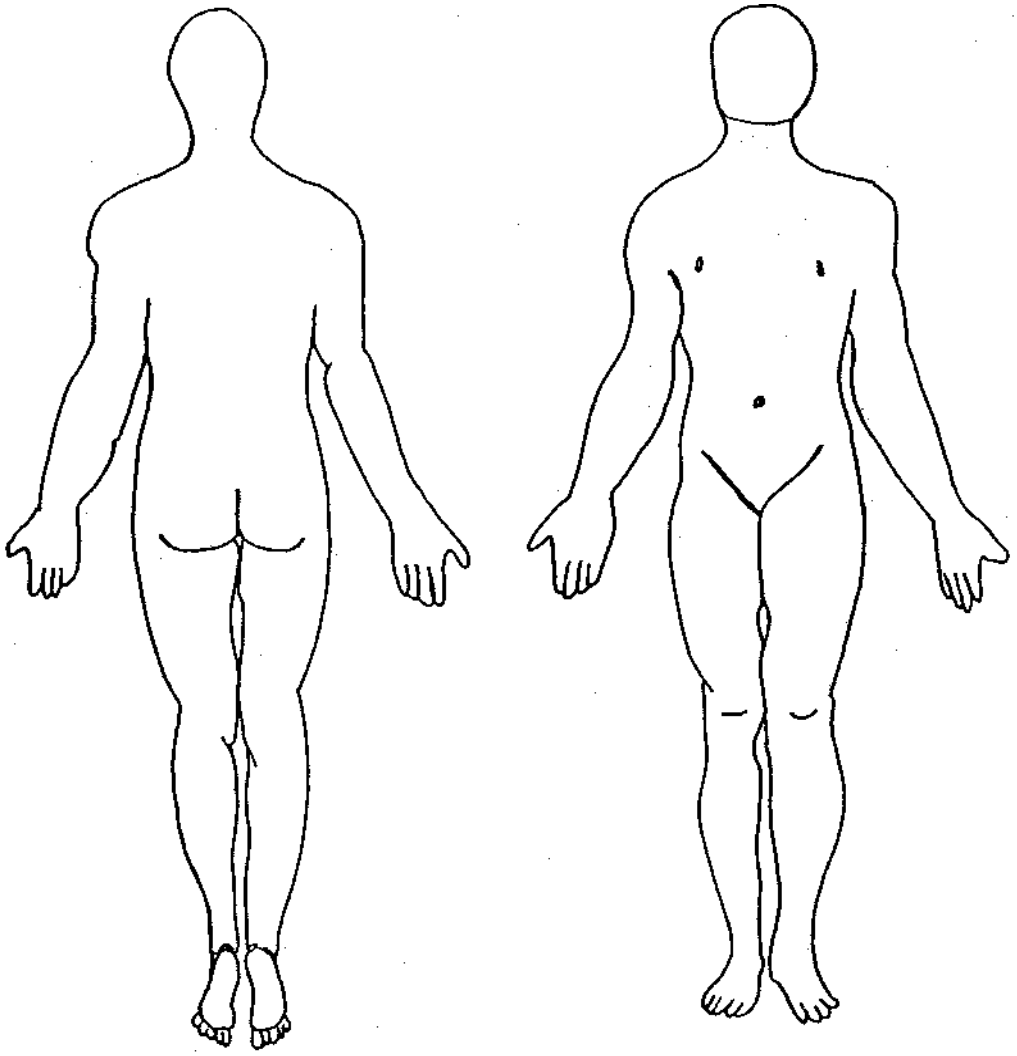
NAME: _____ **DATE:** _____

PLEASE FILL OUT THIS PAIN DIAGRAM TO THE BEST OF YOUR ABILITY. MARK THE AREAS ON YOUR BODY WHERE YOU HAVE PAIN, AREAS OF NUMBNESS OR TINGLING, OR ANY OTHER BOTHERSOME SENSATION. PLEASE INCLUDE ALL AFFECTED AREAS AS WELL AS THE RADIATION OF SYMPTOMS. USE THE APPROPRIATE SYMBOLS BELOW. **PLEASE FILL OUT THE PAIN SCALE.**

NUMBNESS:00000 **PINS & NEEDLES:**XXXXX **PAIN OR ACHE:**/////



RATE YOUR PAIN	0=NO PAIN									10=EXTREMELY INTENSE
RIGHT NOW:	1	2	3	4	5	6	7	8	9	10
AT ITS WORST:	1	2	3	4	5	6	7	8	9	10
AT ITS BEST:	1	2	3	4	5	6	7	8	9	10

NEWPORT ORTHOPEDIC INSTITUTE

Neck & Back History

Name:_____

Age:____ Date of Injury:___/___/___ Place of Injury:_____

Please describe what area of your neck and back hurts you:_____

_____

_____

Describe exactly how your injury began:_____

_____

_____

How frequent is your pain: *Occasional* *Intermittent* *Frequent* *Constant*

How severe are your symptoms? *Mild* *Slight* *Moderate* *Severe*

How would you rate your pain on a scale of 0 to 10 with ten being the worst imaginable pain?

At the time you first experienced the pain:_____

What would you rate your pain now:_____

What would you rate it at its least over the past two weeks:_____

What would you rate it at its worst over the same two weeks:_____

What type of pain do you have? *Sharp* *Dull* *Aching* *Stabbing* *Electrical*

Where does your pain radiate? *Buttock* *Thigh* *Calf* *Foot* *Elbow* *Forearm* *Hand*

Is your Back/Neck pain: *Worse than,* *Less than, or* *Equal to* any leg or arm pain?

What kind of arm or leg symptoms do you have?

Numbness *Tingling* *Weakness* *Fatigue*

NEWPORT ORTHOPEDIC INSTITUTE

Neck & Back History

Of the actions below, circle those that make your pain worse:

Bending *Lifting* *Sitting* *Driving* *Deskwork* *Housework* *Coughing*

Straining *Sneezing* *Standing* *Walking* *Lying down*

Of the actions across, cross out those that make your symptoms better.

List medications that you have tried for this problem._____

_____

Which of the medications have helped?_____

Have you had Physical Therapy? *Yes* *No* Where?_____

Did it help you? *Yes* *No*

Do you experience loss of bowel of bladder control or awareness? *Yes* *No*

_____

Please circle if you experience: *Fever* *Chills* and/or *Night sweats*

Have you experienced a sudden change in weight either up or down? *Yes* *No*

Is this injury related to your work? *Yes* *No*

Is this injury related to an automobile accident? *Yes* *No*

Have you had back surgery? *Yes* *No* If so, when _____

What was done?_____

List any prior medical treatment:_____

_____

_____

List any prior similar complaint:_____

_____

_____