beach cities orthopedics
& sports medicine

SPINE EVALUATION

Name:____Date:____________Birthdate:_______________

Gender: Male Female Occupation:_________________________Athlete/School________________

Name of referring physician?____

Brief description of your problem: ____

____

What body part(s) are involved?________________________ What side of the body? ☐R ☐L ☐ Both

When did it start? Days ________ Weeks _________ Months ________ Years___________

What are your expectations today?

☐Explanation or Diagnosis ☐Tests ☐Medicines
☐Therapy ☐Injection ☐Schedule surgery

Check the **ONE** that best describes how your problem started:

( ) **NO INJURY- onset was ____Gradual ____Sudden** Why do you think it started?__________________

____

( ) **INJURY- ____Accident ____Sport** Date of Injury__________ Sport?_________ School?_____________

( ) **WORK RELATED** Date of Injury/Pain_____________ How?_________________________________

( ) **AUTO ACCIDENT Date**__________________

1. On a scale of 0-10 (10 is the worst) how severe is your pain?(Circle) 0 1 2 3 4 5 6 7 8 9 10
2. Check the ones that describe your pain: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning
3. The pain is: ☐Constant ☐Come and goes
4. Does your pain wake you from your sleep? ☐Yes ☐No
5. What Percent of your pain is in your: Neck_____% Arms______%
   Back:_____% Legs ______%
6. Since your problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged
7. What makes your symptoms worse? ☐Standing ☐Walking ☐Running ☐Getting Up ☐Stairs
   ☐Sitting ☐Lying down ☐Twisting ☐Lifting ☐Gripping
8. Do You have any of the following:
   ☐Numbness ☐Tingling ☐Weakness ☐Difficulty with Buttons ☐Bowel/Bladder Symptoms
9. Have you had any of these treatments? ☐Injection ☐Brace ☐Physical Therapy ☐Crutches
10. What tests/scans have you had for this problem?
    ☐X-ray ☐MRI ☐CAT scan ☐Bone Scan ☐Nerve test (EMG/NCV)
11. Have you had surgery for this problem? ☐Yes (list below) ☐No
    Surgery Date(s)/Physician(s)/Procedure(s):____
    ____
    ____
12. List Doctors who have treated you- Please include Name/Specialty/City/Date
    ____
    ____
13. Current Work status:
    ☐Regular ☐Light duty (how long____________) ☐Not working due to problem
    ☐Disabled ☐Retired ☐Student
14. When is the last date you worked your regular job? ___________________________
15. Have you applied for or are receiving: ☐Disability ☐Workmen's Comp ☐Unemployment

Patient Statement: To the best of my knowledge, the above information is accurate.

Signed:____Date:________________________