Back & Lower Extremity Assessment

Patient Name: _____ Visit Date _____/ _____/ _____

My worst symptom is:
- ☐ Pain
- ☐ Numbness, tingling or loss of sensation
- ☐ Weakness
- ☐ Other: _____

PAIN

☐ I have **NO** pain

My pain is never lower than

a ___ out of 10

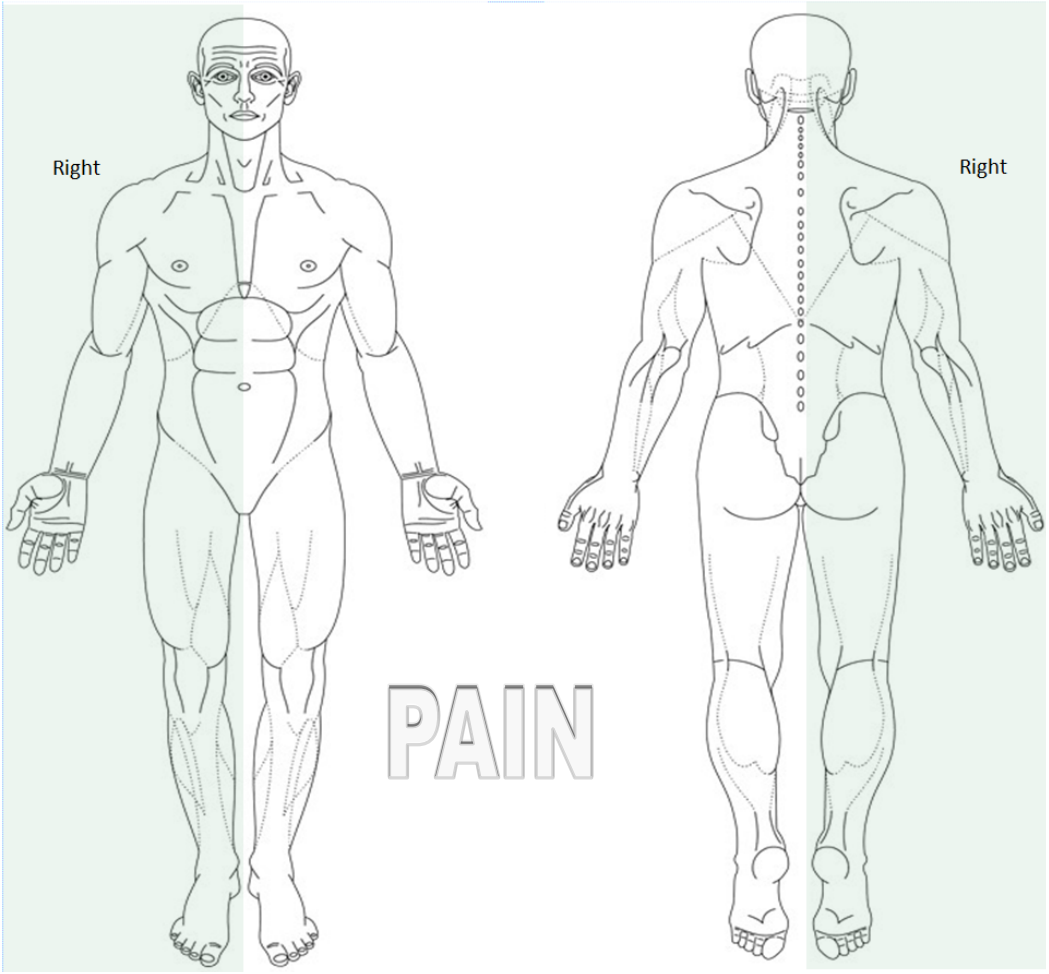
At it's worst the pain is

a ___ out of 10

Pain seems to hover about

a ___ out of 10.

Quality of pain:
- ☐ Sharp/stabbing
- ☐ Throbbing
- ☐ Dull/achy
- ☐ Burning
- ☐ Electrical/zapping
- ☐ _____



☐ My back pain is more than my sciatic pain

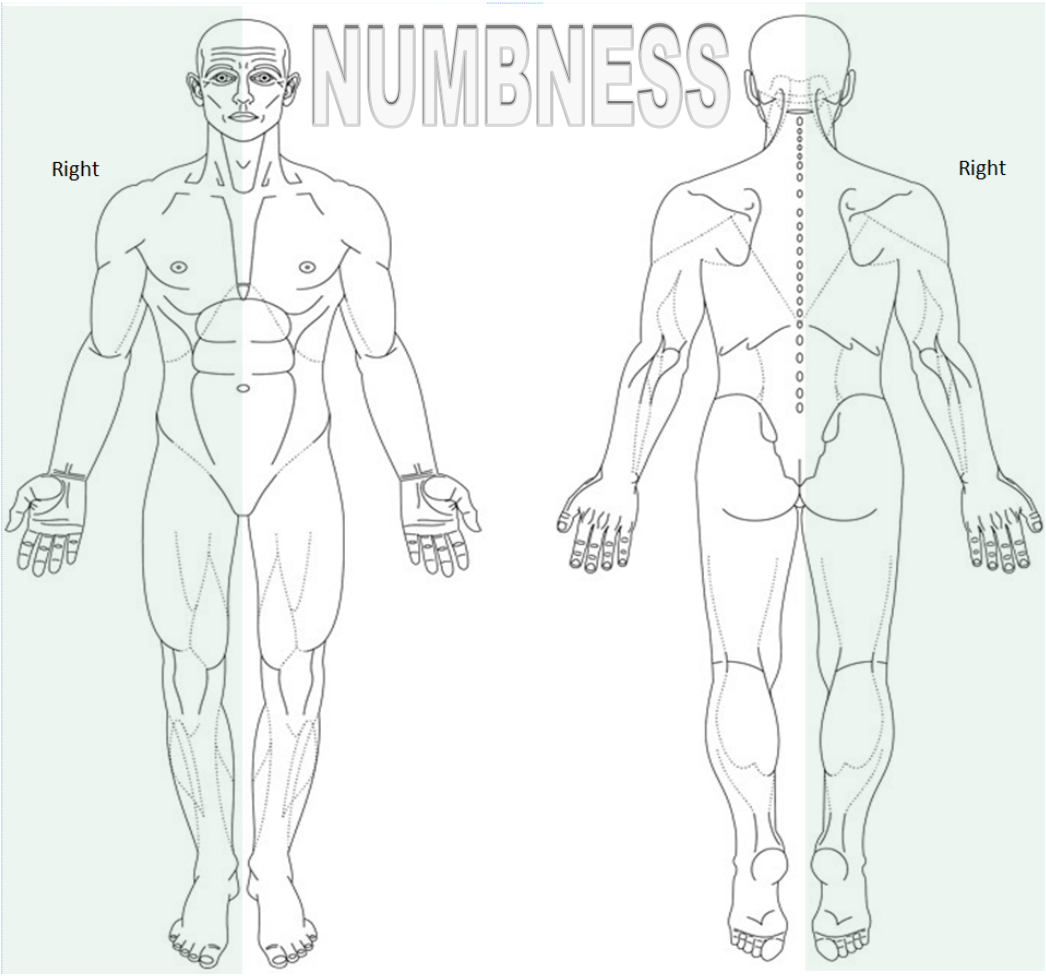
☐ My sciatic pain is more than my backpain

☐ Back and sciatic pain are equal

Numbness Tingling or Loss of Sensation

☐ I do **NOT** have any loss of sensation or numbness/ tingling

☐ I **DO** have loss of sensation/ numbness/tingling have - it is in a similar location to pain



Weakness

Any difficulty with any of the following?:	**RIGHT**	**LEFT**	**None**
Lifting your thigh at the hip, like when stepping up or getting out of bed?"	☐	☐	☐
Bringing your thighs together, like when crossing your legs?	☐	☐	☐
Moving your leg backward, like when standing up from a chair, walking uphill, or pushing off when running?	☐	☐	☐
Straightening your leg at the knee, like when standing up or walking?	☐	☐	☐
Pulling your foot or your big toe up toward your shin, like when walking, climbing stairs, or keeping your toes from dragging on the ground?	☐	☐	☐
Pushing your foot down, like pressing on a gas pedal or standing on your tiptoes?	☐	☐	☐
Coordination—are you clumsy, do you have difficulty with fine motor (like difficulty buttoning buttons or picking up pills?) **OR do you have clumsiness in your legs?** (like the ground feels strange)	☐	☐	☐

☐ I have trouble walking anything but a short distance because of incapacitating symptoms in my back and legs.

☐ I have leg pain, numbness, or weakness that worsens with walking or standing and improves when sitting or bending forward.

Patient Name: _____ Visit Date _____/ _____/ _____

Other Symptoms

_____

_____

_____

_____

ONSET

When did your symptoms start and what were you doing at the time?

_____

_____

_____

_____

Progression

Since your symptoms began, have they improved, worsened, or stayed the same?

_____

_____

_____

_____

What makes your symptoms worse?

_____

_____

_____

What interventions have you recently tried to improve your symptoms?

☐ Rest ☐ Ice / Heat ☐ Brace ☐ Over the counter pain medications ☐ Prescription pain medications

☐ Chiropractic therapy ☐ Massage therapy ☐ Injections ☐ Physical therapy ___ wks/6mos

_____

_____

_____

What makes your symptoms better?

_____

_____

_____

Lifestyle

What areas of your life are significantly impacted by your <u>current</u> condition?

☐ Work ☐ Exercise & fitness ☐ Sleep ☐ Sex-life ☐ Weight gain ☐ Weight loss

☐ Household chores ☐ Enjoyable activities ☐ Mental well-being ☐ Hygiene