Patient Name: _____ Visit Date _____/ _____/ _____

PAIN

BACK PAIN ☐ None - I DO NOT have pain

Location:
- ☐ Upper chest
- ☐ Middle chest
- ☐ Lower chest
- ☐ Upper low back
- ☐ Mid low back
- ☐ Low low back
- ☐ SI joint (Right/Left)

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

Intensity of Back Pain:

Never less than a ___ out of 10

At worst the pain is ___ out of 10

Usually the pain is a ___ out of 10

LOWER EXTREMITY PAIN ☐ None - I DO NOT have pain

Location - RIGHT:
- ☐ Buttock
- ☐ Groin/Inguinal region
- ☐ Hip (back/front/inner/outer)
- ☐ Thigh (back/front/inner/outer)
- ☐ Knee (back/front/inner/outer)
- ☐ Leg (back/front/inner/outer)
- ☐ Ankle (back/front/inner/outer)
- ☐ Foot (top/bottom/inner/outer)
- ☐ Toes (Great/2/3/4/5)

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

Intensity of Lower Extremity pain:

Never less than a ___ out of 10

At worst the pain is ___ out of 10

Usually the pain is a ___ out of 10

Location - LEFT:
- ☐ Buttock
- ☐ Groin/Inguinal region
- ☐ Hip (back/front/inner/outer)
- ☐ Thigh (back/front/inner/outer)
- ☐ Knee (back/front/inner/outer)
- ☐ Leg (back/front/inner/outer)
- ☐ Ankle (back/front/inner/outer)
- ☐ Foot (top/bottom/inner/outer)
- ☐ Toes (Great/2/3/4/5)

SENSORY CHANGES

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

☐ I have loss of sensation or numbness/tingling that is similar in location to my pain

There are other places that I have loss of sensation or numbness/tingling: _____

_____

_____

WEAKNESS

1) Do you feel weakness when lifting your leg at the hip, like when stepping up or getting out of bed?"

☐ No trouble ☐ Yes on the right ☐ Yes on the left

2) Do you have trouble bringing your thighs together, like when crossing your legs?

☐ No trouble ☐ Yes on the right ☐ Yes on the left

3) Do you have trouble moving your leg backward, like when standing up from a chair, walking uphill, or pushing off when running?

☐ No trouble ☐ Yes on the right ☐ Yes on the left

4) Do you have trouble straightening your leg at the knee, like when standing up or walking?

☐ No trouble ☐ Yes on the right ☐ Yes on the left

5) Do you have difficulty 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?

☐ No trouble ☐ Yes on the right ☐ Yes on the left

6) Do you have trouble pushing your foot down, like pressing on a gas pedal or standing on your tiptoes?

☐ No trouble ☐ Yes on the right ☐ Yes on the left

OTHER SYMPTOMS

Do you get pain, numbness, or weakness in your legs when walking or standing for a while, and does it feel better when you sit down or lean forward, like when pushing a shopping cart? ☐ No ☐ Yes

_____

_____

_____

Patient Name: _____ Visit Date _____/ _____/ _____

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 actions make your symptoms worse?

_____

_____

_____

What actions make your symptoms better?

_____

_____

_____

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

_____

_____

_____

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

What would you most like to do that you can not now do because of your current condition?

_____

_____

_____