L.D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine

Back Evaluation Sheet

The problem which brought me to the doctor today is:

1) ☐ Low back pain or discomfort ☐ Middle back pain or discomfort ☐ Abnormal curvature of back (i.e. scoliosis)
2) ☐ Buttock and/or ☐ leg pain or discomfort on the ☐ right side or ☐ left side
3) ☐ Leg more painful ☐ Back more painful

For:

1) ☐ Neck pain or discomfortt ☐ Shoulder pain or discomfort
2) ☐ Upper back pain or discomfort ☐ Arm/hand pain or discomfort on the ☐ right side or ☐ left side
3) ☐ Neck more painful ☐ Shoulder more painful ☐ Arm more painful

Please draw the discomfort pattern below:

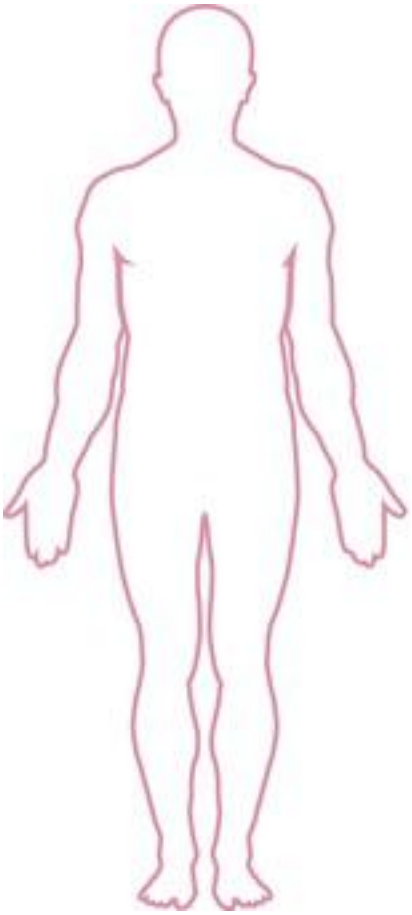
Mark areas of your body where you feel the described sensations. Use the appropriate symbol.

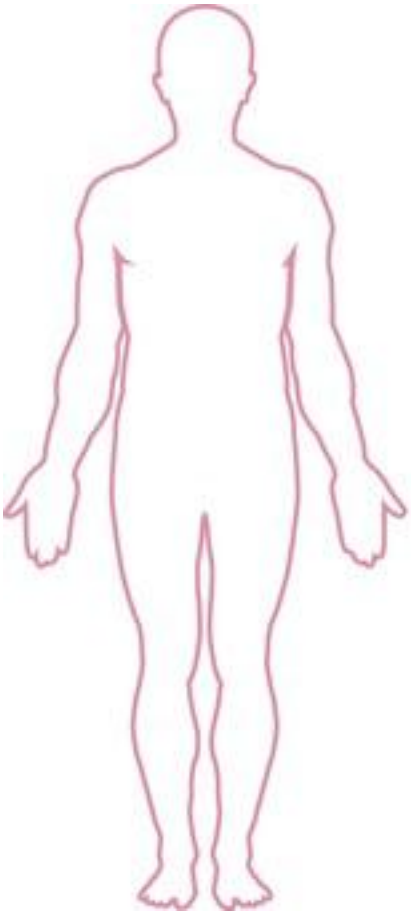
Mark the areas of radiation. Include all affected areas.

Ache ^^^^^^ Numbness °°°°°° Pins & Needles ====== Burning xxxxxx Stabbing ///////

Front Back

Right Left Left Right





Right Left Left Right

Front Back

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Mark "X" on the line:

1) How bad is your low back pain?

0_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Possible

2) How bad is your leg pain now?

0_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Possible

3) How bad is your neck or upper back pain now?

0_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Possible

4) How bad is your arm pain right now?

0_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Possible

Explain how your pain began:

☐ Injury ☐ On the job Explain how it happened: _____

_____ Date of Injury: _____

☐ I don't know how it began

☐ My problem is chronic Age it began_____ ☐ I remember an injury

Describe injury: _____

Previous Treatment (for neck or back):

☐ None

☐ Yes-physician's name: _____

He prescribed:

Medications (give names):

☐ Anti-Inflammatories_____	☐ no help	☐ some relief	☐ much relief
☐ Muscle relaxers_____	☐ no help	☐ some relief	☐ much relief
☐ Pain meds_____	☐ no help	☐ some relief	☐ much relief
☐ Others_____	☐ no help	☐ some relief	☐ much relief
☐ Physical Therapy	☐ no help	☐ some relief	☐ much relief
☐ Traction	☐ no help	☐ some relief	☐ much relief
☐ Exercises	☐ no help	☐ some relief	☐ much relief
☐ Injections: Describe_____	☐ no help	☐ some relief	☐ much relief
☐ Manipulation (osteopath)	☐ no help	☐ some relief	☐ much relief

Chiropractor's name: _____

☐ Heat ☐ Ice	☐ no help	☐ some relief	☐ much relief
☐ Surgery (Age_____) Describe: _____	☐ no help	☐ some relief	☐ much relief

_____

I have had the following tests:

☐ Regular X-rays

☐ CAT scan

☐ MRI

☐ Myelogram

☐ Discogram

☐ EMG

☐ I have seen other doctors for my condition. List types of doctors and who they were: _____

_____

_____

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The following make my discomfort better:

Neck ☐ Bed rest ☐ Massage ☐ Stretching/"popping" neck ☐ Other_____
☐ Nothing helps ☐ Heat ☐ Ice

Back ☐ Bed rest ☐ Decreased activities ☐ Bending forward ☐ Bending backward ☐ Bending neck to the left
☐ Bending neck to the right

The following make my discomfort worse:

Neck ☐ Activity ☐ Bending neck forward ☐ Bending neck backward ☐ Bending neck to the left
☐ Bending neck to the right

Back ☐ Activity ☐ Bending forward ☐ Bending backward ☐ Sitting ☐ Standing ☐ Walking
☐ Sneeze/cough/strain

☐ Other: _____

I also have the following problems:

☐ Specific weakness of muscles in arms or hands

☐ Generalized weakness of arms or hands due to pain or discomfort

☐ Numbness ☐ Tingling of: ☐ arms ☐ hands
☐ legs ☐ feet ☐ toes

☐ Specific weakness in legs

☐ Generalized weakness of legs due to pain and discomfort

☐ My legs fatigue or hurt when I walk too far
- ☐ This is relieved by resting my legs
- ☐ I can walk ☐ less than a block ☐ 1-2 blocks ☐ more than 3 blocks

☐ Trouble with my bladder (urine) control
- ☐ Can't empty bladder
- ☐ Loss of urine (accidents)

☐ Trouble with bowels
- ☐ Constipation
- ☐ Loss of control (accidents)

☐ My pain is worse at night

☐ My pain awakens me from sleep

Job History:

My job is: _____

My job requirements are:

☐ Heavy-Lifting over 60 lbs/frequent bending and stooping

☐ Medium-Lifting 30-50 lbs

☐ Light-Lifting 10-20 lbs

☐ Sedentary-Sit most of the time, very little lifting

☐ My job is highly stressful, it makes me tense