Lumbar Initial History Form

When did your symptoms start?. _____

How did they start (MVA, fall, woke up with pain, etc.)? _____

_____

_____

My symptoms are in my right/left/both (circle one): ___ back ___ buttock ___ hip

___ thigh (front/back/middle/outside) ___ leg (shin/outer calf/back of calf)

___ inside/outside/top/bottom foot (circle all that apply)

My pain level is (circle the appropriate number):

On average
0----1----2----3----4----5----6----7----8----9----10

At its worst
0----1----2----3----4----5----6----7----8----9----10

My symptoms feel like: ___ numbness ___ tingling ___ stabbing ___ burning ___ achy

___ pins and needles ___ other: _____

My symptoms are worse when I: ___ bend ___ twist ___ lift ___ sit ___ drive ___ walk ___ stand

___ housework ___ lie down ___ other: _____

My symptoms are better when I: ___ bend ___ twist ___ lift ___ sit ___ drive ___ walk ___ stand

___ housework ___ lie down ___ other: _____

I have tried: ___ PT (Dates _____) ___ Chiropractor ___ Heat ___ Ice ___ Massage ___ Traction

___ Pain meds or Muscle relaxants (please list _____)

___ Epidurals (Dates _____) ___ Other injections (Types _____)

Previous spinal surgeries (Date/Procedure/Surgeon)

_____

_____

Other symptoms: ___ fever ___ chills ___ nausea ___ vomiting ___ night sweats ___ night pain

___ weigh loss/gain ___ bowel problems ___ loss of urinary control