

409 NORTH SIXTH STREET • LONGVIEW, TEXAS 75601  
TELEPHONE 903-758-2746 • FAX 903-758-7127

## SPINE PATIENT ENCOUNTER FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. WHAT KIND OF PAIN ARE YOU HAVING?**

(CHECK ALL THAT APPLY)

- BACK PAIN
- NECK PAIN
- LEFT LEG PAIN
- RIGHT LEG PAIN
- LEFT ARM PAIN
- RIGHT ARM PAIN

**PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING.**

(CHECK ALL THAT APPLY)

- | Sharp                    | Dull                     | Aching                   | Stabbing                 | Throbbing                |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN.**

(CIRCLE)

- |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

2. HOW LONG HAVE YOU BEEN HAVING PAIN? \_\_\_\_\_ DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_ MONTHS \_\_\_\_\_ YEARS

**3. WHAT IS THE RATIO OF BACK TO LEG PAIN?**

- 100% BACK / 0% LEG PAIN
- 75% BACK / 25% LEG
- 50% BACK / 50% LEG PAIN
- 25% BACK / 75% LEG PAIN
- 0% BACK / 100% LEG PAIN
- NO BACK / LEG PAIN

**WHAT IS THE RATIO OF NECK TO ARM PAIN?**

- 100% NECK / 0% ARM PAIN
- 75% NECK / 25% ARM PAIN
- 50% NECK / 50% ARM PAIN
- 25% NECK / 75% ARM PAIN
- 0% NECK / 100% ARM PAIN
- NO NECK / ARM PAIN

4. ARE YOUR SYMPTOMS DUE TO AN INJURY?  YES  NO

IF THE ANSWER IS YES, PLEASE GIVE DATE AND EXPLAIN THE DETAILS REGARDING THE INJURY:

---



---



---

**5. IF YOU ARE SUFFERING FROM BACK OR NECK PAIN, WHAT PERCENTAGE OF THE PAIN IS RELIEVED WHEN LYING DOWN IN YOUR MOST COMFORTABLE POSITION?**

- 100% RELIEF WHEN LYING DOWN
- 75% RELIEF WHEN LYING DOWN
- 50% RELIEF WHEN LYING DOWN
- 25% RELIEF WHEN LYING DOWN
- 0% RELIEF WHEN LYING DOWN

**6. WHAT POSITIONS AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> STANDING           | <input type="checkbox"/> WALKING          | <input type="checkbox"/> SITTING      |
| <input type="checkbox"/> FORWARD BENDING    | <input type="checkbox"/> BACKWARD BENDING | <input type="checkbox"/> SIDE BENDING |
| <input type="checkbox"/> GETTING OUT OF BED |   |                                       |

**7. PLEASE DESCRIBE YOUR WALKING TOLERANCE:**

- |   |   |
|---|---|
| <input type="checkbox"/> I CAN WALK INDEFINITELY.       | <input type="checkbox"/> I CAN WALK UP TO AN HOUR.    |
| <input type="checkbox"/> I CAN WALK UP TO 30 MINUTES.   | <input type="checkbox"/> I CAN WALK UP TO 15 MINUTES. |
| <input type="checkbox"/> I CAN WALK LESS THAN 5 MINUTES |   |

**8. HAVE YOU NOTICED ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)**

- CLUMSINESS
- DROPPING OBJECTS MORE FREQUENTLY
- WORSENING HANDWRITING
- UNSTEADY WHEN WALKING
- NONE OF THE ABOVE

**9. HAVE YOU NOTICED ANY CHANGE IN YOUR BODY SHAPE RECENTLY?  YES  NO**

IF YES, THEN OVER WHAT TIME PERIOD? \_\_\_\_\_

**10. WHAT TREATMENTS HAVE YOU HAD FOR YOUR SYMPTOMS? (CHECK ALL THAT APPLY)**

- PHYSICAL THERAPY
- EPIDURAL STEROID INJECTIONS
- FACET BLOCKS
- NSAIDS (MOTRIN, IBUPROFEN, CELBREX, BEXTRA, VIOXX, LODINE, ETC.)
- NARCOTICS (LORTAB, DARVOCET, VICODIN, PERCOET, OXYCONTIN, ETC.)
- ULTRA/ ULTRACET
- CHIROPRACTOR MANIPULATION
- BRACES

**DID THE TREATMENT HELP?**

- YES  NO
- YES  NO
- YES  NO
- YES  NO
- YES  NO
- YES  NO
- YES  NO
- YES  NO

**11. HAVE YOU HAD ANY PREVIOUS SPINE SURGERIES?  YES  NO**

IF YES, PLEASE LIST THE NAME OF THE PROCEDURE, THE DATE AND THE SURGEON:

---

---

---

**12. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)**

- FEVERS
- CHILLS
- NIGHT SWEATS
- WEIGHT LOSS
- NONE OF THE ABOVE

**13. DOES THE PAIN WAKE YOU UP FROM SLEEP AT NIGHT?  YES  NO**

**14. HAVE YOU EVER LOST BOWEL OR BLADDER CONTROL?  YES  NO**

**15. PLEASE SHADE IN THE AREAS ON THE DIAGRAMS THAT CORRESPOND TO YOUR AREAS OF PAIN ON YOUR BODY.**

