



# SPURLOCK

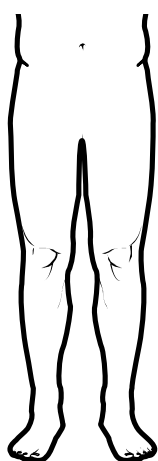
## SPINE CENTRE

### Low Back/Hip/Leg Complaints

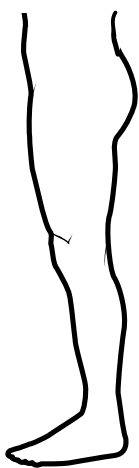
Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_

Circle the areas on your body where you feel the described sensations. Use the appropriate letter(s) and include all affected areas.

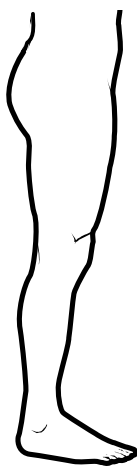
- |           |              |             |                 |                  |             |
|-----------|--------------|-------------|-----------------|------------------|-------------|
| Ache-A    | Cramping-C   | Dull Pain-D | Pins/Needles-Pn | Shooting Pain-Sh | Soreness-So |
| Burning-B | Deep Pain-De | Numbness-N  | Sharp Pain-S    | Stabbing Pain-St | Throbbing-T |



Front



Left



Right



Back

#### Quality

- 1.) Do you experience leg weakness?  No  Yes, Where? \_\_\_\_\_
- 2.) Do you have a fever?  No  Yes  Not sure
- 3.) Do your symptoms INCREASE with a cough/sneeze?  No  Yes; straining with a bowel movement?  No  Yes
- 4.) Do you have any *new* difficulties since this condition began with: **bowel**  No  Yes; **bladder**  No  Yes; **sexual functions**  No  Yes, (describe): \_\_\_\_\_
- 5.) Describe how your pain has changed recently. (Check only ONE statement)  
 Remained about the same  Feeling better  Feeling worse  Erratic
- 6.) Similar or recurrent condition?  No previous episodes  Recurrent problem (for how long): \_\_\_\_\_  
 Similar problem (describe and occurred when): \_\_\_\_\_
- 7.) Pain Scale and Quality: List any other symptoms you are experiencing in this region (In addition to the drawing)  
 Electrical Shock  Tightness  Lancinating Pain  Vague Discomfort  Pops/Cracks  
 Stiffness  Other, (describe): \_\_\_\_\_
- 8.) Please circle the number which best describes your pain level, or if the pain varies, list a range: (0-No Pain and 10-Worst Pain you can imagine): 0 1 2 3 4 5 6 7 8 9 10 or Range: \_\_\_\_\_

**Frequency**

9.) How frequent does your condition occur?  Intermittent (0-25%)  Occasional (26-50%)  Frequent (51-75%)  
 Constant (76-100%)  Times per week: \_\_\_\_\_  Times per month: \_\_\_\_\_  Times per year: \_\_\_\_\_

**Duration**

10.) How long have you had this current episode or condition? \_\_\_\_\_

**Timing**

11.) Describe what caused your problem (if known) and how the problem has progressed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12.) Palliative: What activities or positions REDUCE your pain?

- Nothing       Bending Backward       Heating Pad       Lying on Side       Resting       Twisting
- Any Movement       Bending Forward       Hot Bath/Shower       Lying on Stomach       Sitting       Walking
- Back Brace       Cold Packs       Lying on Back       Raising arms up       Standing
- Other, (describe): \_\_\_\_\_

13.) Provocative: What activities or positions INCREASE your pain?

- Nothing       Bending Backward       Extremes of Movement       Lifting       Lying on Stomach       Standing
- Any Movement       Bending Forward       Heating Pad       Lying on Back       Raising Arms Up       Twisting
- Back Brace       Cold Packs       Hot Bath/Shower       Lying on Side       Sitting       Walking
- Other, (describe): \_\_\_\_\_

14.) Is your condition worse?  Morning  Later in Day  End of Day  At Night  No Pattern

**Previous Treatment**

15.) Previous treatment for this condition:  None

Treatment which IMPROVED this condition: \_\_\_\_\_

Treatment which did NOT IMPROVE this condition: \_\_\_\_\_

Length of treatment for each type of treatment: \_\_\_\_\_

List Hospital(s), Doctor(s), therapist(s) and the year seen: \_\_\_\_\_  
\_\_\_\_\_

List tests performed, where performed, and year (x-rays, MRI, CT scan, bone scan, EMG/NCV, etc): \_\_\_\_\_  
\_\_\_\_\_

**Functional Capacity**

16.) Functional limitations due to pain: How may pounds can you lift? \_\_\_\_\_ How long can you stand? \_\_\_\_\_  
How long can you sit? \_\_\_\_\_ How long can you walk? \_\_\_\_\_

17.) Have you been totally disabled from your work?  No  Yes; home-maker duties?  No  Yes  
How long? \_\_\_\_\_

18.) Have you been partially disabled from your work?  No  Yes; home-maker duties?  No  Yes  
How long? \_\_\_\_\_