



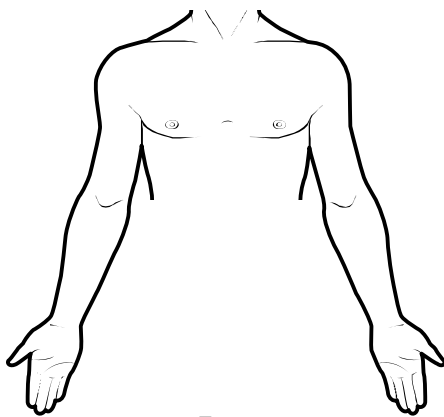
# SPURLOCK SPINE CENTRE

## Mid Back/Rib/Chest Complaints

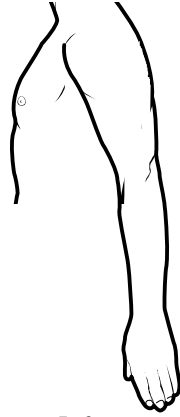
Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name: \_\_\_\_\_

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



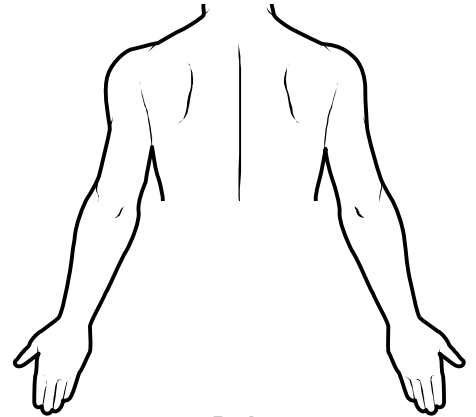
Front



Left



Right



Back

### Quality

- 1.) Do you experience arm or 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: What does your pain feel like? (In addition to the drawing)  
 Electrical Shock  Tightness  Lancing 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     Deep Breathing       Hot Bath/Shower     Lying on Stomach     Standing
- Any Movement     Bending Forward     Extremes of Movement     Lifting       Raising Arms Up     Twisting
- Back Brace       Cold Packs       Heating Pad       Lying on Back       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 many 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? \_\_\_\_\_