

**LUMBAR**

**PERSONAL INFORMATION**

*(Please Print or Type)*

Patient Name: \_\_\_\_\_  
Last First M.I.

Registration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

Telephone Numbers: ( \_\_\_\_\_ ) \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
Home Phone Work Phone

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Phone Number

\_\_\_\_\_  
City State Zip

Dates of Injury/Onset: First Injury/Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Second Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Third Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Fourth Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Source: \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Phone Number

\_\_\_\_\_  
City State Zip

Referring Source is: 1) Physician 2) Chiropractor 3) Other Healthcare Professional  
4) Another Patient 5) Workers Comp 6) Friend  
7) Yellow Pages 8) Other \_\_\_\_\_

Family/Primary Care Physician: \_\_\_\_\_

Emergency Contact: *(A person not living at your residence)*

Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Home: ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse Information:

Name: \_\_\_\_\_  
Last First M.I.

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Attorney: *(Complete only if an attorney is representing you for this injury)*

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Phone Number

\_\_\_\_\_  
City State Zip

Do you want a copy of this report sent to your attorney? **(Circle One)** YES NO

**LUMBAR**

**INSURANCE INFORMATION**

PRIMARY INSURANCE :

\_\_\_\_\_  
Insurance Company ( \_\_\_\_\_ ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street \_\_\_\_\_ Suite \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group #: \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

RELATIONSHIP: (**Circle One**)      Self      Spouse      Mother      Father

SECONDARY INSURANCE :

\_\_\_\_\_  
Insurance Company ( \_\_\_\_\_ ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street \_\_\_\_\_ Suite \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group #: \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

RELATIONSHIP: (**Circle One**)      Spouse      Mother      Father      Self

WORKER'S COMPENSATION :

\_\_\_\_\_  
Insurance Company ( \_\_\_\_\_ ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street \_\_\_\_\_ Suite \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

File or Claim #: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Employer at the Time of Injury :

\_\_\_\_\_  
Company ( \_\_\_\_\_ ) \_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street \_\_\_\_\_ Suite \_\_\_\_\_

\_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAIN DRAWING**

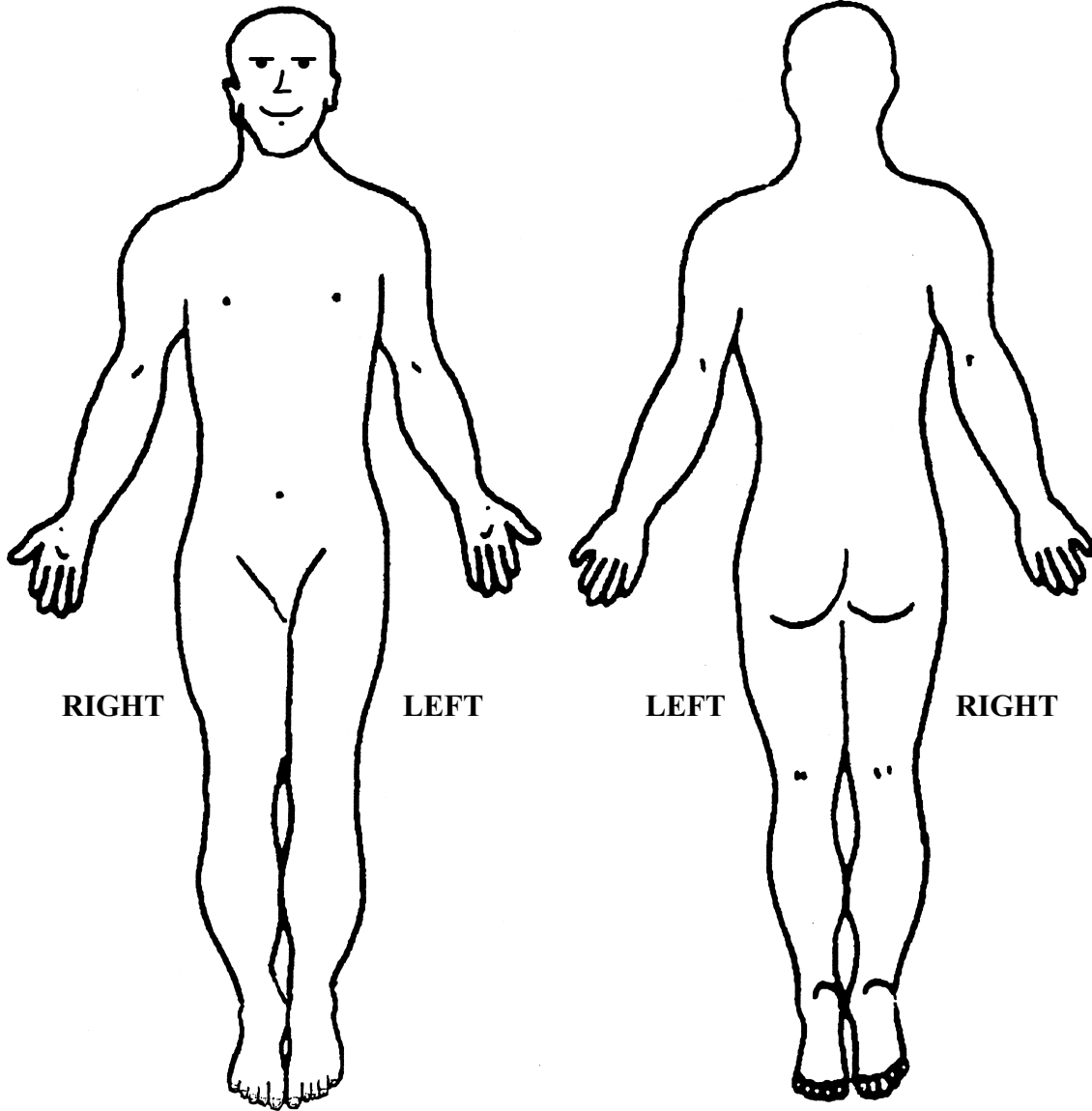
Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**DRAW** the location of your pain on the body outlines below.

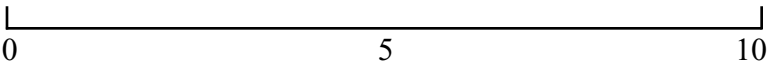
**FRONT VIEW**

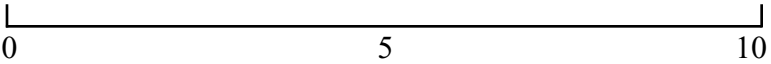
**BACK VIEW**

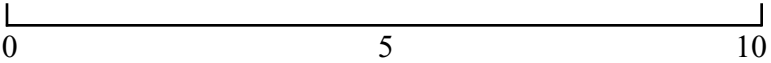


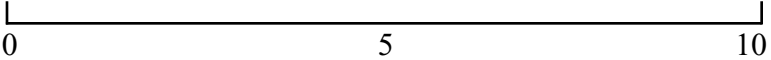
The lines below are diagrammatic representations of your pain level. On a 0 to 10 scale (0 being no pain and 10, being the worst possible pain) please place a vertical mark on each line below to indicate your pain level:

Example: 

Today: 

Most days: 

The worst it gets: 

The least it gets: 

**LUMBAR**

**LUMBAR & THORACIC HISTORY**

LUMBAR & THORACIC SPINE HISTORY OF PRESENT ILLNESS :

1. When did your present pain **BEGIN** (please be as specific as possible)? \_\_\_\_\_

2. Please give the **DETAILS** of your present injury, or onset in the space provided:

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3. Using the following chart, please **Circle** how long you have had your present pain:

- |                         |                   |                        |
|-------------------------|-------------------|------------------------|
| 1 = Less than one month | 3 = 2 to 3 months | 5 = 6 months to a year |
| 2 = 1 to 2 months       | 4 = 3 to 6 months | 6 = More than a year   |

4. Using the following chart, please indicate how your present pain began (**CIRCLE all that apply**):

- |   |  |
|---|--|
| 1 = Unknown                               | 6 = Occurred while walking                   |
| 2 = Occurred while sitting                | 7 = Occurred during an athletic activity     |
| 3 = Occurred while bending                | 8 = Occurred as a result of an auto accident |
| 4 = Occurred while lifting                | 9 = Occurred as a result of a fall           |
| 5 = Occurred while twisting               | 10 = Occurred as a result of a trauma        |
| 11 = Other - Please Explain Briefly _____ |  |

5. Is this injury work related?

- |                |               |                   |
|----------------|---------------|-------------------|
| 1 = <b>Yes</b> | 2 = <b>No</b> | 3 = <b>Unsure</b> |
|----------------|---------------|-------------------|

6. Please indicate where your present pain was initially located: (**CIRCLE ONE**)

- |                |                |                       |
|----------------|----------------|-----------------------|
| 1 = Unknown    | 3 = Mid back   | 5 = Low back and legs |
| 2 = Upper back | 4 = Lower back | 6 = Legs              |

7. How have the symptoms of your present pain changed since they began? (**CIRCLE ONE**)

- 1 = No change in symptoms
- 2 = Increased aggravation in one leg
- 3 = Increased aggravation in both legs
- 4 = Increased aggravation in the back
- 5 = Increased aggravation in legs & back

8. Please **CIRCLE** the most appropriate statement:

- 1 = My symptoms have remained the same since the time of injury
- 2 = My symptoms are more severe since the time of injury
- 3 = My symptoms are less severe since the time of injury

9. Compare the Pain in your **BACK** to the pain in your (Buttock, Thigh, Leg & Foot)? (**Circle One**)

- 1 = 100% Back pain and 0% Buttock, Thigh, Leg & Foot pain
- 2 = 80% Back pain and 20% Buttock, Thigh, Leg & Foot pain
- 3 = 60% Back pain and 40% Buttock, Thigh, Leg & Foot pain
- 4 = 50% Back pain and 50% Buttock, Thigh, Leg & Foot pain
- 5 = 40% Back pain and 60% Buttock, Thigh, Leg & Foot pain
- 6 = 20% Back pain and 80% Buttock, Thigh, Leg & Foot pain
- 7 = 0% Back pain and 100% Buttock, Thigh, Leg & Foot pain

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10. Circle **ANY** and **ALL** areas of weakness (Right, Midline, and/or Left):

- |            |   |       |         |      |
|------------|---|-------|---------|------|
| ANKLE/FOOT | - | Right |         | Left |
| KNEE       | - | Right |         | Left |
| HIP        | - | Right |         | Left |
| LOW BACK   | - | Right | Midline | Left |
| MID BACK   | - | Right | Midline | Left |
| UPPER BACK | - | Right | Midline | Left |

11. Please rate your pain over recent weeks using the following scale:

- 1 = no pain
- 2 = mild pain
- 3 = moderate requiring mild pain medications such as Tylenol or aspirin
- 4 = severe causing you to markedly modify your activities and/or take strong medications such as codeine or other narcotics and prescription drugs
- 5 = so intense you can barely function
- 6 = so excruciating that it is unbearable

1.	At its worst	1	2	3	4	5	6
2.	Most of the time (usual)	1	2	3	4	5	6
3.	At its best (least)	1	2	3	4	5	6
4.	In the morning:						
	a) before getting out of bed	1	2	3	4	5	6
	b) after getting out of bed	1	2	3	4	5	6
5.	Midday	1	2	3	4	5	6
6.	Evening	1	2	3	4	5	6
7.	Night time	1	2	3	4	5	6

12. Which of the following activities **CHANGES** your pain? (*checkmark (✓) all that apply*):

	Aggravates Pain	Relieves Pain
1. Sitting	_____	_____
2. Rising from sitting	_____	_____
3. Leaning forward (brushing teeth)	_____	_____
4. Bending forward	_____	_____
5. Driving	_____	_____
6. Standing	_____	_____
7. Walking	_____	_____
8. Lying on your side	_____	_____
9. Lying on your back	_____	_____
10. Lying on your stomach	_____	_____
11. Coughing/Sneezing	_____	_____

Now go back and put an asterisk (\*) next to the most aggravating and the most relieving activity.

13. Please answer the following questions:

- 1. How many minutes can you sit in one position before having to move? \_\_\_\_\_
- 2. How long can you stand in one position before having to move? \_\_\_\_\_
- 3. How long can you walk before having to stop or sit? \_\_\_\_\_
- 3b. If walking is uncomfortable, will stopping and standing in one position (not sitting) relieve the majority of the pain? (Please **Circle**)      YES      NO

14. Please estimate how many hours you spend from 7:00 a.m. to 11:00 p.m. each day performing the following activities:

1. Working	_____	5. Sitting	_____
2. Driving	_____	6. On couch/recliner	_____
3. Housekeeping	_____	7. In bed	_____
4. Walking	_____	8. Other major activity	_____

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### PAST BACK HISTORY

15. Which of the following treatments have you tried? Please place a checkmark (✓) to indicate the effect of those which have been used in an attempt to heal your present injury. (Do **NOT** mark those not tried):

	Not Helpful	Helpful	For How Long?
1. Physical Therapy	_____	_____	_____
2. Epidural Block/Injections	_____	_____	_____
3. Facet Block/Injection	_____	_____	_____
4. Exercises	_____	_____	_____
5. Traction	_____	_____	_____
6. Gravity Inversion Traction	_____	_____	_____
7. Hot Packs	_____	_____	_____
8. Ice Packs	_____	_____	_____
9. TENS Unit	_____	_____	_____
10. Ultrasound	_____	_____	_____
11. Back School	_____	_____	_____
12. Chiropractor	_____	_____	_____
13. Acupuncture	_____	_____	_____
14. Other: _____	_____	_____	_____

16. Please indicate with a checkmark (✓) if you have had any of the following studies.

Also, please indicate the Month & Year, if known:

1. Plain X-ray of Back	_____	4. Myelogram	_____
2. CT scan	_____	5. Discogram	_____
3. MRI	_____	6. EMG	_____

17. You have already given us the necessary information about your present pain; now please give the following information about any other previous episodes of back problems.

- a. Approximate dates: Episode A: \_\_\_/\_\_\_/\_\_\_  
 Episode B: \_\_\_/\_\_\_/\_\_\_  
 Episode C: \_\_\_/\_\_\_/\_\_\_  
 Episode D: \_\_\_/\_\_\_/\_\_\_

b. Using the following chart, please circle the number(s) that indicate(s) where the symptoms of these other injuries were located:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Unknown	=	1	1	1	1
Low back	=	2	2	2	2
Low back and legs	=	3	3	3	3
Legs only	=	4	4	4	4
Mid back	=	5	5	5	5
Upper back	=	6	6	6	6

c. Using the following chart, please **CIRCLE** the number that indicates how long the symptoms of your other injuries lasted:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Less than one month	=	1	1	1	1
1 to 3 months	=	2	2	2	2
3 to 6 months	=	3	3	3	3
6 months to one year	=	4	4	4	4
More than one year	=	5	5	5	5

d. Using the following chart, please circle the number that indicates the severity of your pain at the time of these other injuries:

	Episode:	<u>A</u>	<u>B</u>	<u>C</u>	<u>D</u>
Mild pain	=	1	1	1	1
Moderate pain	=	2	2	2	2
Severe pain	=	3	3	3	3



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MEDICAL, SOCIAL & VOCATIONAL HISTORY

MEDICATIONS

19. What medications do you take at the present time?

- 1. 2. 3. 4. 5. 6. 7. 8.

Now go back and put an asterisk (\*) next to those medications which help relieve your pain.

20. List ALL allergies and the reactions they cause (e.g. "Sulfa drugs cause a rash"):

MEDICAL/SURGICAL HISTORY

21. Have you been treated for any of the following? (Place a checkmark (✓) on ALL that apply):

- High Blood Pressure, Angina, Heart Attack, Asthma, Bronchitis, Pneumonia, Diabetes, Urinary Tract Infection, Bleeding Disorders, Blood Transfusions, Blood Clots in the legs, Blood Clots in the lungs, Hepatitis, AIDS or HIV, Stroke

22. List ALL other major illnesses not mentioned above that have been treated in the past 5 years:

23. List ALL previous surgeries, (excluding the surgeries already detailed):

24. Are you currently under a doctor's care for ANY medical condition? (Circle One) YES NO

25. List all other physicians with whom have consulted in the past 5 years:

Now go back and put an asterisk (\*) next to physicians you have seen in the past 6 months.

FAMILY HISTORY

26. Has anyone in your family ever had any of the following conditions? (Circle ALL that apply)

- 1 = Arthritis, 2 = Back pain, 3 = Neck pain, 4 = Migraine headaches, 5 = Tuberculosis, 6 = Heart trouble, 7 = Cancer: Kind?

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SOCIAL HISTORY

27. Are you: (Circle One) Single Married Divorced Separated Widowed

28. Number of children and ages, if any: \_\_\_\_\_

29. Are you: (Circle One)
1 = Unemployed 2 = Employed 3 = Student 4 = Retired

If you answered "1" or "2" please answer the following questions:

A. How long have you been off work this year?

- 1 = No Time 2 = About 1 week 3 = 2 to 4 weeks 4 = 1 to 2 months 5 = About 2 to 6 months 6 = About 6 months to one year

B. Are you presently working? (CIRCLE ONE) YES NO

C. If you answered "no", please complete the following:

- 1. What was the last date worked? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
2. Is your job still available? YES NO
3. Was your reason for leaving work:
a = Due to circumstances related to this problem
b = Due to circumstances NOT related to this problem

30. Current source of income: (CIRCLE ALL that apply)

- 1 = Spouse 2 = Employer 3 = Social Security 4 = Disability 5 = Unemployment 6 = Workers Compensation 7 = Family (other than spouse) 8 = Other funds

31. Is your income sufficient to meet your needs? (CIRCLE ONE) YES NO

32. Are you a cigarette/cigar smoker? (CIRCLE ONE) YES NO

If you answered "YES", how much do you smoke per day?

- 1 = Less than 1/4 pack per day 2 = 1/4 pack per day (5 cigarettes) 3 = 1/2 pack per day (10 cigarettes) 4 = 3/4 pack per day (15 cigarettes) 5 = 1 pack per day 6 = 2 packs per day 7 = More than 2 packs per day 8 = Other: \_\_\_\_\_

33. Do you drink alcoholic beverages? (CIRCLE ONE) YES NO

If you answered "yes", please circle your average consumption?

- 1 = Less than 4 drinks per month 2 = 1 to 3 drinks per week 3 = 3 to 6 drinks per week 4 = 1 to 2 drinks per day 5 = 3 to 5 drinks per day 6 = More than 5 drinks per day

34. Have you used any "Street Drugs" in the last year? (CIRCLE ONE) YES NO

If you answered "YES", what drug(s) and how often? \_\_\_\_\_

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### REVIEW OF SYSTEMS

34. Please **CIRCLE** any of the following problems which you now have or which you have had in the past 6 months:

**General:**

- 1 = Weight gain
- 2 = Weight loss
- 3 = Appetite change
- 4 = Marked fatigue
- 5 = Unexplained night fever
- 6 = Night sweats
- 7 = Difficulty sleeping
- 8 = Psychological difficulties

**Joints:**

- 1 = Pain
- 2 = Stiffness
- 3 = Redness
- 4 = Swelling

**Lungs:**

- 1 = Chest pain
- 2 = Recurring cough
- 3 = Wheezing

**Cardiovascular:**

- 1 = Chest pain, tightness
- 2 = Palpitations
- 3 = Shortness of breath with normal activities

**Gastrointestinal:**

- 1 = Uncontrolled loss of stool
- 2 = Persistent/recurring belly pain
- 3 = Diarrhea
- 4 = Blood in stool
- 5 = Heartburn
- 6 = Constipation
- 7 = Yellow jaundice
- 8 = Pain with bowel movement

**Urological:**

- 1 = Difficulty with urination
- 2 = Unable to control urine
- 3 = Pain with urination

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Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**Oswestry Pain Questionnaire**

This questionnaire has been designed to give your physician information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section **ONLY ONE BOX** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark one box which *most closely* describes your problem.

Section 1 - Pain Intensity

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers.
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

Section 2 - Personal Care (Washing, Dressing, etc)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, wash with difficulty and stay in bed

Section 3 - Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4 - Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/2 mile
- Pain prevents me from walking more than 1/4 mile
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6 - Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 1/2 hour
- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

Section 7 - Sleeping

- Pain does not prevent me from sleeping
- I can sleep well only by using tablets
- Even when I take tablets I have less than six hours sleep
- Even when I take tablets I have less than four hours sleep
- Even when I take tablets I have less than two hours sleep
- Pain prevents me from sleeping at all

Section 8 - Sex Life

- My sex life is normal and causes no extra pain
- My sex life is normal but cause some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 - Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10 - Traveling

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

**Number of Points:** \_\_\_\_\_

**Total Possible:** \_\_\_\_\_

**Score:** \_\_\_\_\_ %