

LOWER BACK/SPINE PATIENT EVALUATION

NAME: _____

Onset: gradual sudden no injury injury **Date:**_____ **Work related?** no yes

Emergency Department? no yes _____

How, when, and what happened? _____

Have you had a similar problem in the past? If so, describe:

Severity: mild moderate severe incapacitating

Status: improved no change worse resolved

Frequency: persistent intermittent occasional

Location of Pain: no pain lower back (right/left/bilateral) lumbar area (right/left/bilateral)

gluteal area (right/left/bilateral) thighs (right/left/bilateral) legs (right/left/bilateral)

Other: _____

Radiation of Pain?: none back (right/left/bilateral) buttock (right/left/bilateral)

thigh (right/left/bilateral) calf (right/left/bilateral) ankle (right/left/bilateral)

foot (right/left/bilateral) Other: _____

Location of Weakness/Numbness: none lower back lumbar area gluteal area thighs (right/left/bilat)

thigh, frontal (right/left/bilateral) thigh, back (right/left/bilateral) thigh, medial (inside) (right/left/bilateral)

thigh, lateral (outside) (right/left/bilateral) legs (right/left/bilateral) Other: _____

Quality: aching discomforting dull piercing sharp stabbing Other: _____

Symptoms Associated with: bending over climbing stairs lifting lying down pulling pushing

sitting sports (_____) walking exercise twisting Other: _____

Context: failure to improve after physical therapy no relief with bed rest unexplained weight loss

Aggravated by: bending changing positions climbing stairs coughing defecation

lifting pushing sitting standing twisting standing upright walking uphill **Other:** _____

Relieved by: Nothing bending forward exercise heat lying down injection

OTC medication (_____) prescription medication (_____) physical therapy rest sitting

stretching other _____

Gait Aids: Not required Cane Crutches Single crutch Walker Wheelchair ****in place of risk factors***

Associated Symptoms: balance disturbances bladder incontinence bowel incontinence decreased mobility disequilibrium gait disturbances intolerant of medications intolerant of treatments

numbness pain at tailbone rash spasms tenderness tightening in legs tightening in thighs

weakness in legs weakness in thighs whole leg numbness whole leg pain other _____

What has been done so far?

Surgery(type, doctor, and date): _____

X-rays and Date: _____

MRI and Date: _____

EMG and Date: _____

Other diagnostic testing and Date: _____

Injections: _____ Relief felt: None Minimal Moderate Significant

Physical Therapy: _____ Relief felt: None Minimal Moderate Significant

Brace (Describe): _____ Relief felt: None Minimal Moderate Significant

Medication taken for this problem: _____

Function:

Climbing Stairs: Able to Not able to Finds it difficult to

Walking: Unlimited 10 blocks 5 – 10 blocks Limited to walking inside house

What activities do your symptoms prevent you from doing?

