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How often are you having pain now?
 RARELY IF EVER
 OCCASIONAL (1-2 EPISODES PER YEAR)
 RECURRENT (2-3 DAYS EVERY FEW MONTHS)
 FREQUENT (>3 DAYS PER MONTH)
 VERY FREQUENT (EVERY WEEK)

BACK PAIN ASSESSMENT

PERSONAL INFORMATION:

NAME: _____
BIRTH DATE: _____
AGE: _____ MALE _____ FEMALE _____
MARITAL STATUS: _____ Married _____ Divorced
_____ Single _____ Separated

Describe your pain as;
(C) CONSTANT (D) DULL
(I) INTERMITTENT (T) THROBBING
(S) SHARP (B) BURNING

_____ NECK _____ BUTTOCK/HIP
_____ MID BACK _____ DOWN LEG
_____ LOW BACK _____ OTHER

DATE FILLING OUT: _____

BACK SYMPTOMS:

Where is your pain and for how long?

<u>LOCATION</u>	<u>DURATION</u>
NECK	_____
MID BACK	_____
LOW BACK	_____
BUTTOCK OR HIP	_____
DOWN THE LEG	_____
OTHER	_____

What time of day is your pain usually worse?

_____ MORNING _____ SAME ALL DAY
_____ MID-DAY _____ AT NIGHT IN BED
_____ EVENING

What makes your pain worse?

_____ LYING DOWN _____ BENDING FORWARD
_____ SITTING _____ BENDING BACK
_____ STANDING _____ COUGHING
_____ WALKING _____ SNEEZING
_____ LIFTING _____ SLEEPING
_____ TWISTING _____ OTHER

Was the onset of your present pain?

_____ SUDDEN (MIN.) _____ SUDDEN(HRS)
_____ GRADUAL (DAYS) _____ GRADUAL(WEEKS)
_____ OTHER; _____ UNKNOWN

What makes your pain better?

_____ LYING DOWN _____ BENDING FORWARD
_____ SITTING _____ BENDING BACK
_____ STANDING _____ MEDICATION
_____ WALKING _____ PHYSICAL THERAPY
_____ NOTHING _____ OTHER

What was the cause of your pain?

_____ UNKNOWN _____ HIT IN THE BACK
_____ LIFTING _____ AUTO ACCIDENT
_____ TWISTING _____ BENDING
_____ FALL _____ PULLING

Do you believe your pain is related to a work injury?

_____ NO _____ POSSIBLE
_____ YES; DATE INJURED: _____

When having pain is it generally....

_____ MILD DISCOMFORT OR LESS
_____ DULL PAIN, WORSE AT TIMES
_____ HARD ACHING PAIN, FREQUENTLY WORSE
_____ SEVERE PAIN, SHARP/ SHOOTING AT TIMES
_____ VERY SEVERE, SHARP, SHOOTING, DISABLING
_____ SEVERE & DISABLING

Since the onset, is your pain getting...

_____ RAPIDLY WORSE _____ RAPIDLY BETTER
_____ SLOWLY WORSE _____ SLOWLY BETTER
_____ UNCHANGED

Since the onset of this episode of pain, have you had any...

_____ NUMBNESS IN THE FOOT; LEFT, RIGHT, OR BOTH
_____ NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
_____ BLADDER PROBLEMS
_____ BOWEL PROBLEMS
_____ PAIN THAT WAKES YOU FROM SLEEP
_____ FEVER, CHILLS, SHAKES, SWEATS
PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.

Prior to the onset of this episode of pain, had you noticed any...

- NUMBNESS IN FOOT; LEFT,RIGHT, OR BOTH
- NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
- BLADDER PROBLEMS
- BOWEL PROBLEMS
- PAIN THAT WAKES YOU FROM SLEEP
- FEVER, CHILLS, SHAKES,SWEATS

PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.

WORK AND RECREATIONAL ACTIVITIES

Are you presently employed?

NO; HOW LONG SINCE YOU WERE?

YES; WHERE AND FOR HOW LONG?

WHAT IS YOUR OCCUPATION?

(PRESENT)

(PREVIOUS OCCUPATIONS)

Activities at home or work mostly involve;

- MANUAL LABOR, HEAVY LIFTING
- MANUAL LABOR, LESS STRENUOUS
- SITTING MOST OF THE DAY
- WALKING OR STANDING MOST OF THE DAY
- HOUSE WORK AND CHILD CARE
(# _____ CHILDREN)

How is the pain limiting your job and/or home activities?

- NOT LIMITED IN ANY WAY
- NOT LIMITED MUCH DUE TO PAIN
- ABLE TO WORK AROUND THE PAIN
- MUST STOP AND LIMIT ACTIVITIES
- UNABLE TO WORK FOR DAYS AT A TIME
- UNABLE TO WORK AT ALL DUE TO PAIN

Has your present episode of pain prevented you from working your regular job?

- NO
- NOT APPLICABLE
- YES; HOW MANY WORK DAYS MISSED?

What activities have you enjoyed in the past that pain prevents you from enjoying today?

How much is your pain limiting your social, recreational, and other activities?

- NOT LIMITED IN ANY WAY
- NOT LIMITED MUCH DUE TO PAIN
- ABLE TO DO MOST THINGS WITH THE PAIN
- MODIFY ACTIVITIES TO CONTROL THE PAIN
- GREATLY LIMIT ACTIVITIES TO CONTROL PAIN
- UNABLE TO PARTICIPATE IN ANY ACTIVITIES

EVALUATION & TREATMENT

What other medical/osteopathic doctors, Chiropractors have you seen for your problems?

(List names and dates)

Doctors: _____

Chiropractors: _____

What studies have been done?

(List where and when)

- NONE
- XRAY; _____
- CT SCAN; _____
- MYELOGRAM; _____
- MRI SCAN; _____
- BONE SCAN; _____
- EMG; _____

What treatment have you received?

(List by whom and when)

- NONE
- MANIPULATIONS; _____
- BRACE/CORSET; _____
- PHYSICAL THERAPY; _____
- SPINALBLOCK; _____
- HOSPITALIZED; _____
- OTHER; _____

Do you take any medication for your pain?

- NO
- YES; LIST MEDICATIONS AND DOSAGES

Have you had back surgery?

- NO
- YES; LIST TYPE, DATE AND SURGEON.
DID IT HELP YOUR PAIN? _____

PAST MEDICAL HISTORY:

Please rate your general health.

- EXCELLENT FAIR
- GOOD POOR

Do you have any medical problems for which you regularly see a doctor?

- NO
- YES; LIST DOCTOR AND PROBLEM:

Have you had surgery?

(OTHER THAN BACK SURGERY)

- NO
- YES; LIST TYPE, DATE, AND SURGEON:

Have you ever been seriously injured?

- NO
- YES; DETAILS AND DATES:

Have you ever been hospitalized?

- NO
- YES; WHEN AND WHERE:

Do you have any allergies to medications?

- NO
- YES; LIST DRUG(S) AND REACTION(S):

Please list your current medications and dosages.

Have you ever been evaluated/treated for substance (drugs/alcohol)dependence?

- NO
- YES; WHEN, WHERE, AND BY WHOM?

Have you ever been treated for emotional/psychiatric problems?

- NO
- YES; WHEN, WHERE, AND BY WHOM?

Did you suffer any unusual childhood illness?

- NO
- YES; WHAT AND WHEN?

FAMILY HISTORY:

Are there any medical problems that tend to run in your family?

- NO
- YES; LIST FAMILY MEMBER AND CONDITION:

Do back problems tend to run in your family?

- NO
- YES; LIST FAMILY MEMBER AND CONDITION:

ANY BACK SURGERY? NO YES

SOCIAL HISTORY:

What is the highest level of education you have completed?

- GRADE SCHOOL COLLEGE
- HIGH SCHOOL GRADUATE SCHOOL
- TRADE SCHOOL

Do you like you work?

- YES
- NOT APPLICABLE
- NO; WHY NOT?

Do you like your boss/supervisor?

- NO
- NOT APPLICABLE
- YES

In the past have you been unable to work because of pain?

- NO
- NOT APPLICABLE
- YES; HOW MANY DAYS TOTAL

Have you had past work related back injuries?

NO
 YES; LIST HOW AND WHEN _____

Do you exercise on a regular basis?

NO
 YES; DOING WHAT, HOW MANY DAYS/WEEK?

Do you smoke or chew tobacco?

NO
 YES; HOW MUCH?

Do you drink alcohol (beer, wine, liqueur)?

NO
 YES; HOW OFTEN /MUCH

Have any of the following reasons caused you to be emotionally upset recently?

NOT UPSET MARITAL SOCIAL
 WORK LEGAL FINANCIAL
 OTHER _____

If your condition does not improve, what will your future plans include?

Do your religious beliefs prevent you from receiving blood transfusion if medically necessary?

NO
 YES

MEDICAL LEGAL INFORMATION:

Have you ever been involved in a medical law suit?

NO
 YES; PLEASE EXPLAIN

Are you involved in a medical lawsuit now?

NO
 YES; PLEASE EXPLAIN.

Is an attorney currently involved with your back problem?

NO
 YES; PLEASE EXPLAIN

REVIEW OF SYSTEMS:

PLEASE INDICATE IF YOU NOW HAVE (OR HAVE HAD IN THE PAST) PROBLEMS WITH ANY OF THE FOLLOWING;

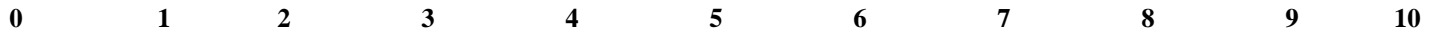
- | | |
|---|---|
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> WEIGHT GAIN | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> FEVER, CHILLS, SWEATS | <input type="checkbox"/> SLEEP |
| <input type="checkbox"/> POOR CIRCULATION | <input type="checkbox"/> MUSCLE CRAMPS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIATAL HERNIA |
| <input type="checkbox"/> VISION | <input type="checkbox"/> STOMACH ULCER |
| <input type="checkbox"/> SEVERE INDIGESTION | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> DENTURES/CAPS | <input type="checkbox"/> GALL BLADDER |
| <input type="checkbox"/> LOOSE TEETH | <input type="checkbox"/> PANCREATITIS |
| <input type="checkbox"/> CHIPPED TEETH | <input type="checkbox"/> BOWEL DISEASE |
| <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> DRK/BLOODY STOOL |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> PELVIC PAIN |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> KIDNEY STONES |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> BLADDER |
| <input type="checkbox"/> BRONCHITIS/PNEUMONIA | <input type="checkbox"/> INFECTIONS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> HISTORY CANCER |
| <input type="checkbox"/> HEART ATTACK/HEART FAILURE | |
| <input type="checkbox"/> HEART MUMMUR | <input type="checkbox"/> ARTHRITIS/GOUT |
| <input type="checkbox"/> ARRYTHMIA | <input type="checkbox"/> SEIZURES/FITS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> WOUND |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> INFECTIONS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> ANESTHESIA |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> AIDS/HIV |

PAIN SCALE:

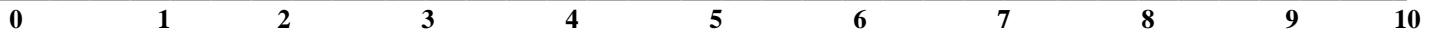
* How much of your total pain is from your back, and how much is from your buttock,hip, or leg?

100% TOTAL PAIN=_____ % BACK PAIN + _____ % BUTTOCK ,HIP, OR LEG PAIN.

* Please rate your pain when it is LEAST bothersome by placing a single mark on scale below.
(0 = NO PAIN) (10= WORST PAIN IMAGINABLE)



*Please rate your pain when it is MOST bothersome by placing a single mark on the scale below



PAIN DRAWING :

On the figures below please indicate where you are having any:

*Draw arrows to show where pain goes or shoots

*Please indicate where the pain is worse

*Be sure to show ALL areas involved

ACHING/PAIN (XXXX)

NUMBNESS/TINGLING (0000)

PINS/NEEDLES (.....)

BURNING (///)

SPASM/CRAMP (VVVV)

