SOUTHERN CALIFORNIA
SPINE & JOINT
INSTITUTE

LOW BACK PAIN

Please mark the appropriate boxes below

Name: _____ DOB: _____

1. **When did you first start feeling the current episode of back symptoms?**

   ☐ _____weeks ☐_____months ☐ _____years

   a. Did this pain begin after a significant trauma or injury? If so, please describe:

   _____

2. **Where is your back pain located?**

   ☐ Throughout the lower back ☐ Right side of the lower back ☐ Left side of the lower back

3. **Does the back pain radiating down into your buttocks, hips, thighs, legs, or feet?** ☐ Yes No

   If yes, where:

☐ Left buttocks	☐ Right buttocks	☐ Both buttocks
☐ Left hip	☐ Right hip	☐ Both hips
☐ Left inner thigh	☐ Right inner thigh	☐ Both inner thighs
☐ Left outer thigh	☐ Right outer thigh	☐ Both outer thighs
☐Left front of the thigh	☐Right front of the thigh	☐Front of both thighs
☐ Left back of the thigh	☐ Right back of the thigh	☐ Back of both thighs
☐ Left knee	☐ Right Knee	☐ Both knees
☐ Left calf	☐ Right calf	☐ Both calves
☐ Left shin	☐ Right shin	☐ Both shins
☐ Inside of left foot	☐ Inside of right foot	☐ Inside of both feet
☐ Outside of left foot	☐ Outside of right foot	☐ Outside of both feet
☐ Top of left foot	☐ Top of right foot	☐ Top of both feet
☐ Bottom of left foot	☐ Bottom of right foot	☐ Bottom of both feet
☐ Entire left foot	☐ Entire right foot	☐ Both feet

4. **Do you have any numbness or tingling in your legs or feet?** ☐ Yes ☐ No

☐ Numbness in the left leg	☐ Tingling in the left leg
☐ Numbness in the left foot	☐ Tingling in the left foot
☐ Numbness in the right leg	☐ Tingling in the right leg
☐ Numbness in the right foot	☐ Tingling in the right foot
☐ Numbness in both legs	☐ Tingling in both legs
☐ Numbness in both feet	☐ Tingling in both feet

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5. How would you describe your pain?

☐ Aching ☐Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness

6. In the past week, how would you grade the severity of your low back pain <u>on average</u> on a scale from 0 to 10? Zero being nothing, 10 being the worst pain imaginable

☐0 ☐1 ☐ 2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

7. Are you currently taking any prescription medication(s) to treat your low back pain? If yes, please list below or provide list.

Medication	**Dose**	**How often?**
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Is there anything you do that makes the pain worse?

☐ Driving a car ☐ Cooking ☐ Performing housework ☐ Climbing stairs ☐Exercising ☐ Lifting ☐ Sleeping
☐ Moving without wheelchair/cane/walker ☐ Standing for prolonged periods ☐ Performing work duties
☐ Sitting for prolonged periods ☐ Performing sitting to standing transfers ☐ Walking long distances

9. Have you tried any treatments in the past for your pain? If yes, what treatments?

☐ Physical Therapy ☐ TENS therapy ☐ Pool therapy ☐ Epidural Steroid Injection(s) ☐ Chiropractic
☐ Spine Surgery ☐ Acupuncture ☐ Nerve Blocks ☐ Radiofrequency ablation ☐ Medications
☐ Massage ☐ Home exercise ☐ Orthotics/Bracing ☐ Traction ☐ Ice ☐ Heat

a. **If you've participated in physical therapy, when was the last time you did so?**

_____

b. **If you've had epidural steroid injections, when was your last one?**

_____

<u>Diagnostic Studies</u>

1. Have you had any recent radiologic exam(s) related to your low back pain?

☐ MRI ☐ CT Scan ☐ X-Ray ☐ Ultrasounds ☐ Bone Scan ☐ None

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Allergies

Please list any known allergies: If none, please write none.

_____

_____

Medication History

1. **Please list ALL medications you are taking, if any**

Medication	**Dose** (mg, mcg…)	**How often** (once, twice, 3 times daily…)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. **Do you take any blood thinning medication (i.e. Coumadin, Plavix, Aspirin)?**

☐ No ☐ Yes **If yes, medication name:** _____

   a. **Who is the cardiologist or doctor that prescribes this medication?**

      Name_____ **Phone #**_____

3. **What pharmacy would you like medications sent to if necessary?**

   Pharmacy: _____ City: _____

   Cross Streets: _____

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Medical History

Please list all past and present medical problems / medical history, including mental/psychological problems: (high blood pressure, high cholesterol, diabetes, heart attack, stroke, lung disease…)

☐High Blood Pressure ☐High Cholesterol ☐Diabetes (Type 1 / Type 2) ☐Heart Attack

☐Stroke ☐COPD ☐Congestive Heart Failure ☐Coronary Artery Disease ☐Anxiety / Depression

☐Asthma ☐HIV ☐Hepatitis (A / B / C) ☐Blood Clots ☐Acid Reflux

☐Gout ☐Thyroid Disease ☐Other (please list):_____

_____

Have you ever been diagnosed with cancer? ☐No ☐Yes: _____

If yes, what kind? _____

Social History

1. **Do you currently smoke tobacco?**
   ☐ Yes daily ☐ Yes sometimes ☐ No ☐ Former smoker
2. **Do you currently drink alcohol?** ☐ Yes ☐ No
   How often? ☐ Socially ☐ Occasionally ☐ Heavily ☐Lightly
   What kind? ☐Beer ☐ Wine ☐ Hard Liquor
3. **Do you have any history of alcohol abuse?** ☐ Yes ☐No
4. **Do you have a history of substance abuse or substance use disorder?** ☐ Yes ☐No
   a. **If yes, what substance?** _____

Surgical History

Please list all past surgeries you have had: (appendix, tonsils, hernia, spine surgery…)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signature _____ Date: _____