Orthopedic Care Specialists

SPINE

NAME:________________________________ **DATE:**______________ **DOB:**______________

Are you having back pain? Y N

If yes, where? (Circle One)

Upper/Neck (Cervical) Middle (Thoracic) Lower (Lumbar)

Are you having any arm or leg numbness? Y N

If yes, which arm?	**Right**	**Left**	**Both**
If yes, which leg?	**Right**	**Left**	**Both**

Are you having any arm or leg tingling? Y N

If yes, which arm?	**Right**	**Left**	**Both**
If yes, which leg?	**Right**	**Left**	**Both**

Are you having any leg or arm pain? Y N

If yes, which arm?	**Right**	**Left**	**Both**
If yes, which leg?	**Right**	**Left**	**Both**

How long have you had these symptoms?

Days_______Weeks_______Months_______Years_______

Was there a recent injury to this area? Y N

If yes, what happened and when?____

____

Have you ever had spine surgery? Y N

If yes, where and when? ____

Have you ever had XRays on this area? Y N

Have you ever had an MRI on this area? Y N

Have you ever been diagnosed with cancer? Y N

If yes, what kind and when?____

Have you ever had chemotherapy or radiation? Y N