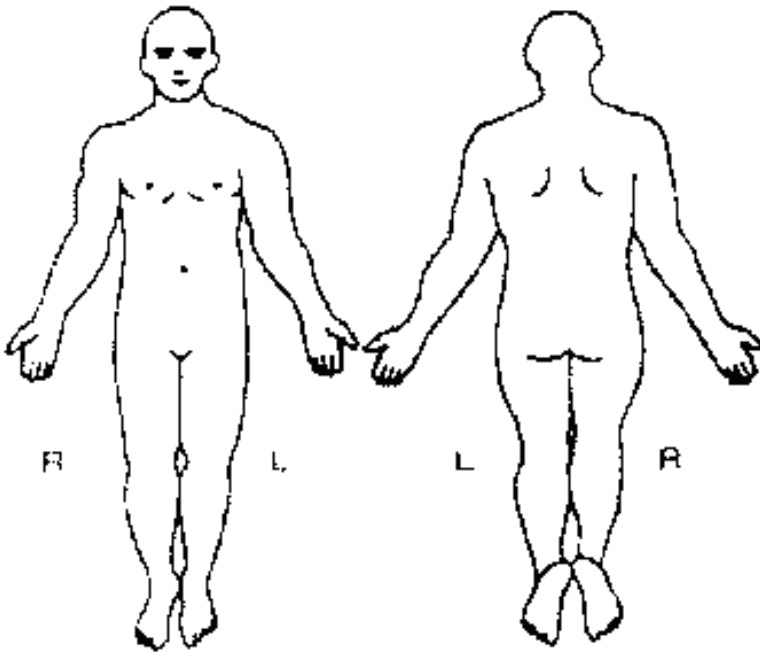


FRONT

BACK



PAIN HISTORY

Mark the drawings to indicate area of pain, numbness, or tingling. Use a pencil to shade in affected areas.

Pain ///////////////

Numbness/Tingling OOOOOO

Previous Spine Surgery? Y N If Yes, what area? _____ When? _____

How long has your pain been this severe? _____

Leg weakness or foot drop? Y N Right Left

ACTIVITIES THAT MAKE YOUR PAIN BETTER OR WORSE:

ACTIVITY	SAME	BETTER	WORSE
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing in one spot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed in morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing up straight after sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough or sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolling over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments: _____

PATIENT LABEL