ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

SPINE HISTORY FORM

Patient Name_____ Date of Birth_____

CHIEF COMPLAINT

1. Give exact date and activity that caused current problem:

2. What are your current symptoms?

3. How long have you had these symptoms?

4. Have you ever had the same or a similar condition? □YES □NO

5. In the last year, have you tried any of the following treatments to relieve your symptoms?

□ physical therapy	□ bed rest	□ reduction of activity
□ pain medication	□ muscle relaxants	□ anti-inflammatory medicine
□ cervical or lumbar traction	□ exercise program	□ chiropractic treatment
□ back brace	□ cervical collar	□ hydrotherapy
□ heat	□ ultrasound	□ massage therapy
□ pain control clinic	□ TENS unit	□ work-hardening program
□ steroid/cortisone injections	□ prednisone/oral steroids	□ other:

6. What medications do you take for pain?

7. Please name all doctors you have seen for this problem:

8. If your symptoms are related to any injury, please mark the box indicating the type of injury

□ Auto injury □ Work-related injury □ Personal injury □ Other_____

9. If work related, did you report this to your employer? □YES □NO

Date of injury_____ if no specific date, when did you first notice your problem?

Patient Name_____ Date of Birth_____

PAIN and FUNCTIONAL INVENTORY

1. How often do you have pain?

   □ Rarely □ Some of the time □ Most of the time □ All of the time

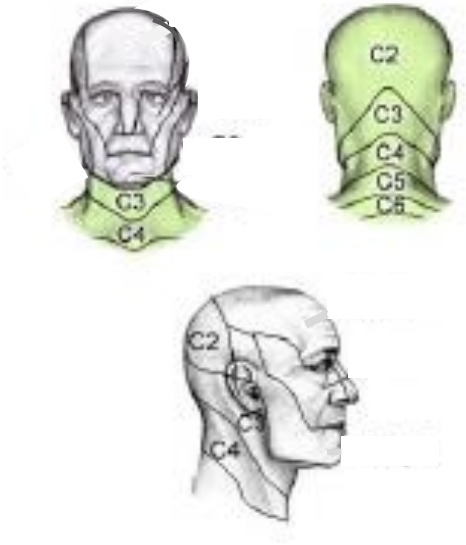
2. Has there been any change in your bowel or bladder function? □ NO □ YES

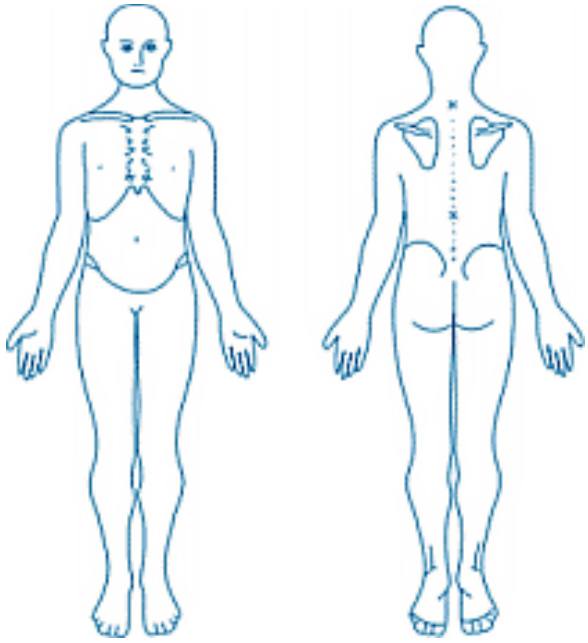
3. Do you have weakness in a leg or arm? □ NO □ YES

4. Do you have radiation of pain, numbness or tingling into an arm or leg? □ NO □ YES

5. Please circle areas of your body where you feel pain.

6. Please draw an arrow to show where you have radiating symptoms:





Please circle a number from 1 to 10 that most closely measures the level of pain you feel

0 1 2 3 4 5 6 7 8 9 10

None hardly noticeable noticeable & wearing worst pain imaginable

On a scale of 0 -10 (10 = all the time) rate the extent your pain has affected each of the following:

Mobility	Sleep	Work	Exercise	Concentration
Social Activities	Relationships with others	Emotions	Other	

Patient Name_____ Date of Birth_____

LOW BACK FUNCTIONAL INVENTORY

It is important for us to know what activities aggravate your pain and what helps to relieve it. Please answer all circumstances. If a question does not apply, please check "N/A"

ARISING	BETTER	WORSE	N/A	PHYSICIAN NOTES
From a chair	□	□	□	
From bed	□	□	□	
From the car	□	□	□	

SITTING	BETTER	WORSE	N/A	PHYSICIAN NOTES
On a hard straight chair	□	□	□	
On a soft couch	□	□	□	
On the floor with legs crossed	□	□	□	

STANDING	BETTER	WORSE	N/A	PHYSICIAN NOTES
In one place	□	□	□	

WALKING	BETTER	WORSE	N/A	PHYSICIAN NOTES
Normal pace	□	□	□	
Briskly	□	□	□	
Uneven surfaces	□	□	□	
Long distances	□	□	□	
Pushing shopping cart	□	□	□	

Patient Name_____ Date of Birth_____

LOW BACK FUNCTIONAL INVENTORY CONTINUED

LYING DOWN	BETTER	WORSE	N/A	PHYSICIAN NOTES
On belly	□	□	□	
On back with legs straight	□	□	□	
On back with legs bent	□	□	□	
On left side	□	□	□	
On right side	□	□	□	

BENDING	BETTER	WORSE	N/A	PHYSICIAN NOTES
Slight bending (brushing teeth, washing dishes)	□	□	□	
Full bending forward (touch knees or toes)	□	□	□	
Returning upright	□	□	□	
Arching backwards	□	□	□	
Side bending left or right	□	□	□	

CHANGING POSITIONS/POSTURES	BETTER	WORSE	N/A	PHYSICIAN NOTES
In general	□	□	□	
Turning in bed	□	□	□	
After sitting or lying for a long time	□	□	□	
From standing to sitting	□	□	□	

Patient Name_____ Date of Birth_____

LOW BACK FUNCTIONAL INVENTORY CONTINUED

EXERCISE/YARD WORK/SPORTS	BETTER	WORSE	N/A	PHYSICIAN NOTES
Beginning	□	□	□	
During activity	□	□	□	
Later/next day	□	□	□	

SUDDEN MOVEMENTS	BETTER	WORSE	N/A	PHYSICIAN NOTES
Cough	□	□	□	
Sneeze	□	□	□	
Bumpy car ride	□	□	□	

STRESS	BETTER	WORSE	N/A	PHYSICIAN NOTES
In general	□	□	□	

How long can you stand? (15 minutes, 1 hour, etc.)

How far can you walk? (yards, miles, 15 minutes, etc.)

Do you consider yourself to be generally flexible or stiff?

How far can you bend over? (touch my toes, ankles, knees, etc.)

Patient Name_____ Date of Birth_____

NECK FUNCTIONAL INVENTORY

IF YOU ARE NOT EXPERIENCING NECK PROBLEMS, PLEASE CHECK HERE □ SKIP TO AND SIGN THE LAST PAGE OF THIS FORM.

If neck pain is a major complaint, please indicate if you are also experiencing the following:

□ Shoulder/upper arm symptoms □ Forearm/hand or finger symptoms

□ Upper back/shoulder blade pain □ Headaches

CHECK ALL THAT APPLY

NECK PAIN		**PHYSICIAN NOTES**
□ Left	□ Right	
□ Lower neck	□ Upper neck	
□ Back of neck	□ Side of neck	
□ Restricts turning right	□ Restricts turning left	
□ Restricts looking up	□ Restricts looking down	
□ With movement		
□ With static positioning (e.g. looking at computer, holding cell phone)		

UPPER EXTREMITY SYMPTOMS		**PHYSICIAN NOTES**
Shoulder/upper arm	□ Left □ Right □ None	
Forearm/hand	□ Left □ Right □ None	
Fingers – if so, which ones?	□ Left □ Right □ None	
Weakness	□ Left □ Right □ None	
Weakness due to pain	□ Left □ Right □ None	
Do symptoms change with different neck positions?	□ YES □ NO	

Patient Name_____ Date of Birth_____

NECK FUNCTIONAL INVENTORY CONTINUED

UPPER BACK/SHOULDER BLADE PAIN	**PHYSICIAN NOTES**
□ Left □ Right □ Both sides	
Are symptoms closer to spine or shoulder blade?	
Pain? □ YES □ NO	
Numbness? □ YES □ NO	
Tingling? □ YES □ NO	
Itch? □ YES □ NO	
Do symptoms change with different neck positions?	

HEADACHES		**PHYSICIAN NOTES**
RIGHT SIDE	LEFT SIDE	
□Back	□ Back	
□Side	□Side	
□Front	□Front	
□Face	□Face	
What will improve your headaches? □ Massage □ Trigger point injections □ Neck traction □ Medications (indicate what kind)		

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge*.**

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____