MedStar Health

MEDSTAR NEUROSURGICAL ASSOCIATES
Patient Information

NECK/BACK INTAKE

Please CIRCLE and DESCRIBE all that apply

Patient Name:_____**DOB:**_____**Age:**_____

Low back pain: Y N pain is: mild/moderate/severe/excruciating/dull/sharp/constant
Any radiation of pain? Yes No Left Right Both sides Is one side worse?_____
Is radiation: mild/moderate/severe/excruciating/dull/sharp/intermittent/constant
Location: buttock/thigh/groin/ hip/leg/ankle/foot/toes (big toe/middle toes/ little toe/heel/bottom of foot)

Neck pain: Y N pain is: mild/moderate/severe/excruciating/dull/sharp/constant
Any radiation of pain? Yes No Left Right Both Sides Is one side worse?_____
Is radiation: mild/moderate/severe/excruciating/dull/sharp/intermittent/constant
shoulder/ shoulder blade/upper chest/ upper arm/ elbow/ forearm/ hand/fingers (thumb/ index/ middle/ ring/ little)

Any: Aching/burning/tingling/numbness If yes side/location:_____
Any: Weakness/loss of use If yes side/location:_____

Date of onset/duration:_____ Initial injury?: yes no
physical activity lifting work accident auto accident assault trip & fall spontaneous gradual onset
Describe any Injury:_____

Any previous episodes of above complaints? No Yes If Yes, When:_____
Please describe prior symptoms:_____
Symptoms **aggravated** by:_____
Symptoms **improved** by:_____

Any changes in bladder or bowel functions? New Incontinence?_____
Are you able to have sexual activity?_____
Any other associated symptoms/depression/sleeping problem?_____

Treatments tried: none/ NSAID/oral steroids/narcotics/ muscle relaxants/antidepressants/gabapentin-lyrica/
physical therapy/chiropractic/massage/acupuncture/spinal injections/rhizotomy

Are activities restricted? Work/housework/exercise/sports/yard work/ shopping/driving/walking
Please describe_____
Physical Therapy within past 12 months or before:_____
Pain Management at any time:_____

Tests performed: none/ spine x-rays/MRI/CT scan/myelogram /EMG/ nerve conduction studies/other