PREMIER
Bone & Joint Centers

A Registered Trade Name of Gem City Bone & Joint, P.C.

Back History Form

1909 Vista Drive
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Lawrence A. Jenkins, M.D. 307-745-8851

NAME _____ AGE _____ DATE _____

1. How did your back or neck pain begin?_____
2. Date of injury (if any)._____
3. How long have you had the pain?_____
4. Where is your pain located?_____
5. Please circle the statement which best describes your back or neck pain.

100% BACK, 0% LEG	100% NECK, 0% ARM
75% BACK, 25% LEG	75% NECK, 25% ARM
50% BACK, 50% LEG	50% NECK, 50% ARM
25% BACK, 75% LEG	25% NECK, 75% ARM
0% BACK, 100% LEG	0% NECK, 100% ARM

6. On a scale of 0 to 10, with 0 being no pain and 10 being your worst pain ever, how would you rate your pain?

   Today? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
   Weekly Average? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

7. What makes your pain WORSE?_____
8. What makes your pain BETTER?_____
9. What MEDICATIONS do you take for the pain?_____
10. Do you have a history of prior back or neck pain, injury, or surgery? If so please describe._____
11. How far can you WALK?_____
12. How long can you SIT?_____ STAND?_____
13. Any problems with bowels, urinating, or sexual functions?_____
14. Type of WORK you do._____
15. Date you last WORKED._____

(over)

NAME_____

DATE_____

PLEASE GIVE THIS PAPER TO THE DOCTOR AT THE TIME OF EXAMINATION

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

____	oooo	xxxx	////
NUMBNESS ____	PINS & NEEDLES oooo	BURNING xxxx	STABBING ////
____	oooo	xxxx	////