Patient Name: ______________________________

Date of Birth: ______________________________

Date of Appt: ______________________________

PREMIER
Bone & Joint Centers

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

FACTOR OF COMPLAINT

What to you want to happen as a result of this visit?

____

____

____

____

____

How/when did your problem begin? (Please mark all that applies to your back/neck pain)

☐ I don't know how it began

☐ It come and goes

☐ I've had it a long time. (______ years)

☐ Injury (date of injury ______)

On the job? ☐ Yes ☐ No

Please explain how the injury happened.

____

____

Are you currently in litigtion with regards to your back pain?
☐ Yes ☐ No

Have you been laid off from your job?
☐ Yes ☐ No ☐ N/A

How bad is your pain? (Place an "X" on each of the lines below to indicate your pain)

How bad is your **low back** pain? No Pain ----------------------------------- Worst possible
How bad is your **leg** pain? No Pain ----------------------------------- Worst possible
How bad is your **middle back** pain? No Pain ----------------------------------- Worst possible
How bad is your **neck** pain? No Pain ----------------------------------- Worst possible
How bad is your **arm** pain? No Pain ----------------------------------- Worst possible

Do you have any of the following problems?

Is your pain worse at night? ☐ Yes ☐ No
Does your pain awaken you from sleep? ☐ Yes ☐ No
Does coughing affect your pain? ☐ Yes ☐ No
Do your legs tire/hurt if you walk too far? ☐ Yes ☐ No
If YES, how far can you walk?
☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks
Is this relieved by resting your legs? ☐ Yes ☐ No
Is this relieved by bending forward? ☐ Yes ☐ No

Bladder Control (urine):
☐ No problem
☐ Can't empty bladder
☐ Loss of urine (accidents)

Bowel Control:
☐ No problem
☐ Constipation
☐ Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	☐ Better	☐ Worse	☐ No Change	
Standing	☐ Better	☐ Worse	☐ No Change	
Walking	☐ Better	☐ Worse	☐ No Change	
Lying down	☐ Better	☐ Worse	☐ No Change	
Rising from chair	☐ Better	☐ Worse	☐ No Change	
Physical activity	☐ Better	☐ Worse	☐ No Change	
Heat	☐ Better	☐ Worse	☐ No Change	☐ Don’t know
Cold	☐ Better	☐ Worse	☐ No Change	☐ Don’t know
Massage	☐ Better	☐ Worse	☐ No Change	☐ Don’t know