MILLER ORTHOPEDIC SPECIALISTS

NECK AND BACK EVALUATION FORM

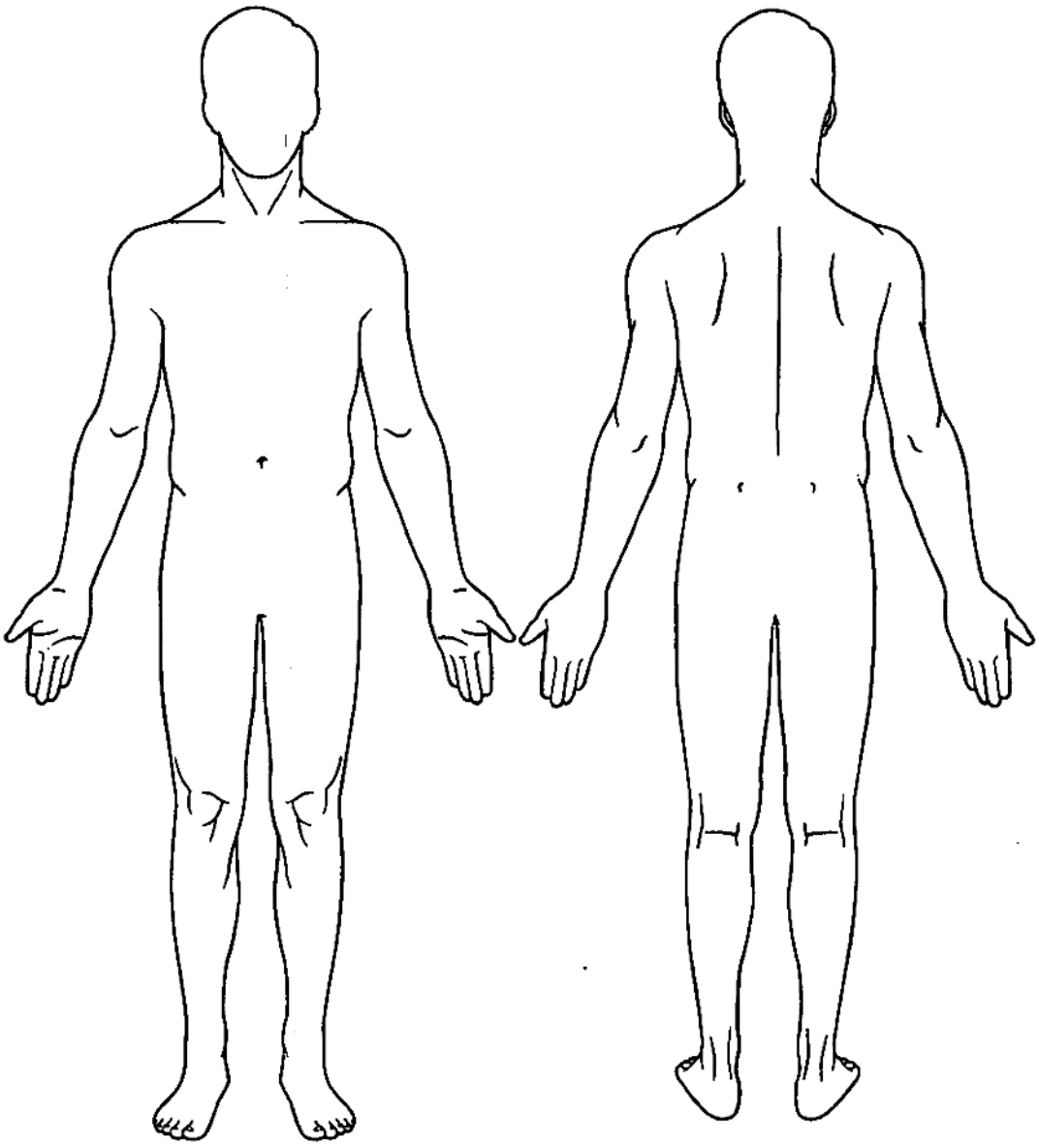
Name _____ Age _____ Date of Birth _____

1. How long has your back bothered you? _____ days _____ weeks _____ months
2. Is this due to an accident? _____ If yes, when did it occur? _____
   Where did it occur? (Include address) _____
   _____
3. Did this injury happen at work? _____
4. Who has treated you for this condition? _____
   Address: _____
5. What treatment and/or medication have you received for this condition? _____
   _____
6. Is the pain in your low back? _____ middle back? _____ between your shoulder blades? _____
   Or in your neck? _____
7. What activities/positions make your pain worse?_____
   _____
8. What activities/positions make your pain better?_____
   _____
9. Do you have headaches associated with the above pain? _____
10. Do you have weakness in your arms or legs? _____
11. If you cough or sneeze, does the pain increase? _____
12. Have you had recent unexplained weight loss? _____ loss of appetite? ____ fever or chills? ___
13. Have you ever had any problems with your back prior to this episode? _____ If so, when? _____
    _____
14. Have you ever had surgery performed on your back? _____
15. If so, when? _____ Who was the surgeon? _____
    Where was the surgery performed? _____

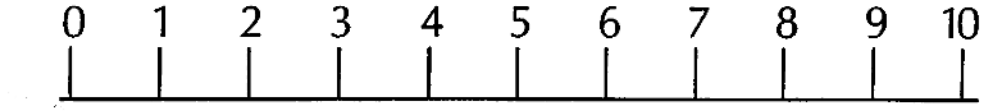
PLEASE TURN PAGE OVER

Please use these symbols to mark your areas of pain and/or numbness on the front and back drawings of this body:

X = Pain 0 = Numbness



Please circle the number below which best represents your level of pain on most days:



no pain worst possible pain