SPINE ASSESSMENT

Wisconsin Brain & Spine Center
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Name: _____ DOB: _____ Date: _____

1. How long have you had back pain? _____ Neck pain? _____
2. Does the pain radiate down your leg? ____ Yes ____ No Down your arm(s)? ____ Yes ____ No
3. How long have you had leg pain? _____ Arm pain? _____
4. Do you have numbness or tingling in your leg or foot? ____ Yes ____ No
5. Do you have leg weakness? ____ Yes ____No Arm weakness? ____ Yes ____ No
6. Do you have bladder or bowel problems (other than constipation)? ____ Yes ____ No
7. What kinds of things make your pain better? (i.e. heat, lying down, pulling knees up, aspirin, etc.)
   _____
8. What kinds of things make your pain worse? (i.e. coughing, sneezing, sitting, straining, standing, walking, etc.)
   _____
9. Do you wake up at night with pain? ____ Yes ____ No
10. Did you injure your back? ____ Yes ____ No Did you injure your neck? ____ Yes ____ No
    a. When? _____
    b. How? _____
    c. Where were you when the injury occurred? _____
    d. Is the injury a work comp claim? ____ Yes ____ No
11. Have you had previous back pain? ____ Yes ____ No Previous neck pain? ____Yes ____ No
12. Have you ever missed work because of your back/neck? ____ Yes ____ No If yes, how long? _____
13. Indicate which, if any, of the following procedure you have had on your lower back or neck as well as the date, location and surgeon.

	Back/Neck	Date of test	Location	Surgeon
a. MRI	_____	_____	_____	_____
b. CT	_____	_____	_____	_____
c. Myelogram	_____	_____	_____	_____
d. Surgery	_____	_____	_____	_____

14. Have you been off work with this current episode? ____ Yes ____ No
    a. Date you stopped working: _____
    b. Date you began modified duty: _____