

Name\_\_\_\_\_

Date\_\_\_\_\_

- 1) Where is the worst pain?
  - a. Leg - right or left?
  - b. Back
  - c. Neck
  - d. Arm - right or left?
- 2) How many spinal injections have you had here in the last 6 months? \_\_\_\_\_
- 3) Are you doing physical therapy? With whom?\_\_\_\_\_
- 4) Pain Level (please circle) 0 1 2 3 4 5 6 7 8 9 10
- 5) Since last visit, the pain has increased / decreased / stayed the same
- 6) What characteristic is the pain? (circle your answer below)  
*aching / burning / stabbing / pressure / numbness*
- 7) Pain duration: *all of the time / most of the time / some of the time / not all the time*
- 8) The position that makes my pain the worst is: Sitting /standing / walking / laying on my side/stomach/back/ bending / driving
- 9) The position that makes my pain the best is: Sitting /standing / walking / laying on my side/stomach/back/ bending / driving
- 10) Any changes in bowel or bladder function? Yes / No (If yes, please describe)\_\_\_\_\_
- 11) Allergies:\_\_\_\_\_
- 12) List **ALL** Medications:\_\_\_\_\_
- 13) New Medical Problems:\_\_\_\_\_



PE:	<b>DTR's</b> 2+ and symmetric Except: Rt. / Lt.	<b>MMT</b> 5/5 throughout Except: Rt. / Lt.	<b>Sensation</b> intact Except: Rt. / Lt.
	Provocative testing:	<b>Dural tension</b> + / - <b>SIJ</b> + / - <b>Hip I.R.</b> + / -	<b>Discogen prov</b> + / - <b>Spurling</b> + / - <b>TTP:</b>
	Babinski/Clonus/Hoffman's +/-		

**Assessment:**

**Radiographic Review:**

**Therapeutic Plan:**

**EMG:**