DISC CENTERS of AMERICA™ CENTRAL FLA.

NON-SURGICAL SPINAL DECOMPRESSION

LOW BACK

Name: _____ **Date Of Birth**: _____ **Date Of Appointment**: _____

Age: _____ **Right or Left-Handed**: _____ **Sex**: _____

Occupation/Profession: _____

Date Of Injury (if appropriate): _____

Description of Injury (if appropriate): _____

How Long have you had the low back pain? _____

What does your pain feel like? Sharp Stabbing Dull Aching Burning Throbbing
(circle all that apply)

How frequently are you experiencing this pain? Constantly Multiple Times A Day Once A Day 1-2 Times per Week
(circle only one)

Where is the pain located? Center of Spine Left of Center Right of Center Left, Right, & Center of Spine
(circle only one)

Does numbness, tingling, or pain run down the arm or leg? Not at All Constantly Daily 1-2+ Times Per Week
(circle only one)

Which side does the numbness, tingling, or pain run down? Right Left Both

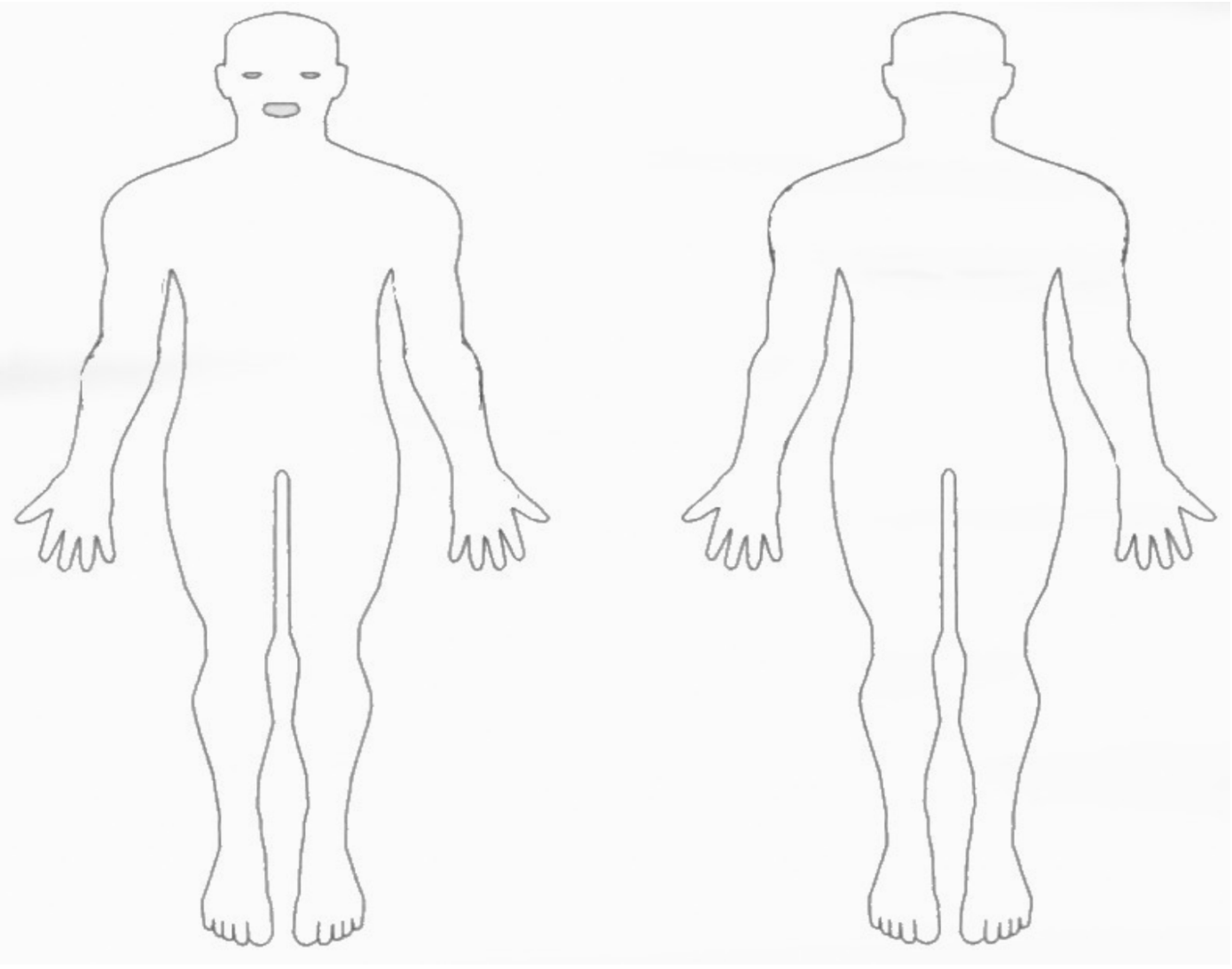
Does the numbness, tingling, or pain radiate to your buttocks? No Yes

Does the numbness, tingling, or pain reach the level of your knees? No Yes

Does the numbness, tingling, or pain reach your ankles? No Yes

Does the numbness, tingling, or pain reach your toes? No Yes

Which is more severe? Pain in my low back Pain in my buttocks/hips Pain in my legs
(circle only one)



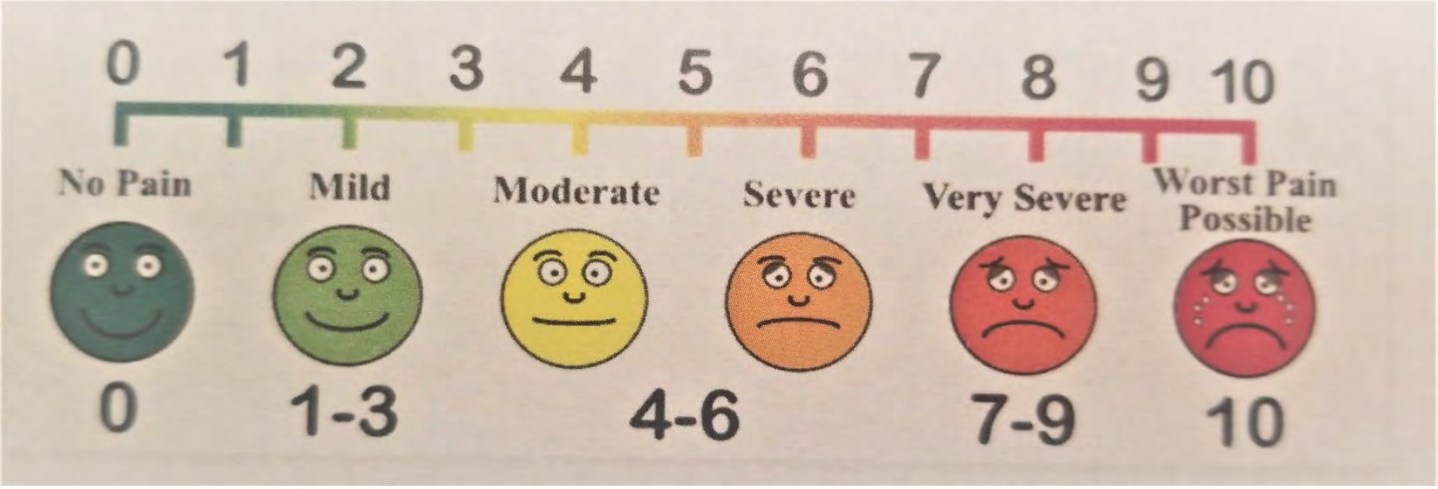
Are you experiencing weakness in the legs? No Yes, both Yes, the right Yes, the left

If yes, how do you notice the weakness?
(circle all that apply)

Entire limb(s) feel weak or heavy	Difficulty standing from a seated position	Difficulty climbing stairs
My knees buckle or feel like they want to "give out".	Trip easily over rugs	Foot slaps the ground

How severe is your pain on a scale from 0 to 10? (Use the scale below to help guide you)

At its best _____ At its worst _____ Average or Usual _____



What things make your pain worse? (circle all that apply)

Prolonged sitting	Walking Uphill	Stress/tension
Prolonged standing	Walking Downhill	Lifting Kids/Bags/Suitcases
Sneezing/coughing	Ascending Stairs	Pushing Shopping Cart
Descending Stairs	Twisting at the Waist	

Other: _____

What is most painful? (Choose one)

Standing then Leaning Backwards

Going from bent over position at the waist to standing upright

Standing then Leaning Forwards

None of the Above

What things make your pain better? (circle all that apply)

No Movement | Stretching | Heat | Medication

Changing Physical Positions | Ice/Cold | Massage | Rest

Corsets/braces | Leaning backwards | Lying on a hard surface

Other: _____

Are you having accidents of bowel or bladder? (circle one)

No | Yes, Bowel | Yes, Bladder | Yes, Both Bowel and Bladder

I have had previous treatment consisting of: (circle all that apply)

Physical therapy | Chiropractic Manipulations | Epidural Steroids | Massage | Acupuncture | Surgery

Previous medications I have tried for this condition: (circle all that apply)

No Medications | Anti-inflammatory | Opioids | Steroid Dose-pak | Muscle Relaxants

Nerve Medications Like Gabapentin or Lyrica

Mild Pain-reliever Like Tylenol

What is the maximum weight you can tolerate lifting without provoking pain? _____lbs
(One gallon of water weighs 8 lbs.)

Habits:

Smoke tobacco:

Yes or No. If yes, packs /day? ____, how many years? ____, Quit? (Yes or No) When?_____.

Drink Coffee / caffeine:

No__/Yes__, how many cups/mugs/cans a day_____.

Drink Alcohol:

No__/Yes__. How many glasses liquor or beers a day____ week____.

Drug Use :

No__/Yes___, Are you in a methadone program? No__/Yes__

Detail type of substance and frequency_____

Medications You Are Taking In General:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies To Medications: _____

Have you had a history of the following:

____Yes ____No Glaucoma
____Yes ____No Diabetes
____Yes ____No Thyroid Disease
____Yes ____No High blood pressure
____Yes ____No Lung Disease
____Yes ____No Heart disease
____Yes ____No Stomach ulcer
____Yes ____No Recent infections
____Yes ____No Cancer (type) _____
____Yes ____No HIV Positive (AIDS)
____Yes ____No Hepatitis B
____Yes ____No Bleeding or blood clots
____Yes ____No Neck or Back pain
____Yes ____No Syphilis
____Yes ____No Arthritis
____Yes ____No Osteoporosis/Osteopenia
____Yes ____No Rheumatoid arthritis
____Yes ____No Spina Bifida

Has any member of your family had a history of the following:

____Yes ___ No Glaucoma

____Yes ____No Diabetes

____Yes ____No Thyroid Disease

____Yes ____No High blood pressure

____Yes ____No Lung disease

____Yes ____No Heart disease

____Yes ____No Stomach ulcer

____Yes ____No Recent infections

____Yes ____No Cancer (type)_____

Any other medical problems? _____

Functional History:

Check **('x")** if you have a problem;

( ) Walking independently I use a cane___ I use a brace____ .
( ) Climbing upstairs independently
( ) Driving Independently
( ) Transfers (get up, bed to chair, sitting to standing).
( ) Dressing yourself (shirt, pants, shoelaces).
( ) Eating/ drinking (cooking).
( ) Self care (urinating, defecating,) and personal.
( ) Hygiene (bathing, brushing, combing, etc.)

Social History:

I live in a House /Apartment / Other_____
How many steps to enter the building? _____
How many steps/stairs to your room?_____
Do you live alone? Yes__ / No__, with whom?_____
If you have a home attendant, #hours/day_____/_____

Functional Work Demands:

Current occupation_____
Primary activities you do at work: Sitting ( ), standing ( ), kneeling ( ), bending forward ( )
bending backward ( ) rotating the trunk ( ) squatting ( ) reaching ( )
How many required hours spent sitting? _____
How many required hours using the computer? _____
How many required hours standing? _____
How much weight is required that you lift? _____

Recreational History:

Practice Sports or exercise? No__ /Yes__. If yes, how many times a week?_____
What kind of sports? _____

What do you enjoy doing (movies/ theater / listening to music /dancing, racing, etc) _____
_____

REVIEW OF SYSTEMS:

Please **CHECK** each that applies to you.

GENERAL:

□yes □no Unexplained changes in weight
□yes □no Fever, Chills, Night sweats

NEUROLOGICAL:

□yes □no Unusual change in voice
□yes □no Seizures
□yes □no Loss of consciousness
□yes □no Memory difficulties
□yes □no Disorientation
□yes □no Difficulty with speaking
□yes □no Difficulty with writing
□yes □no Difficulty with reading
□yes □no Dysphagia
□yes □no Double vision
□yes □no Loss of vision
□yes □no Tremors
□yes □no Difficulty walking
□yes □no Weakness
□yes □no Numbness
□yes □no Changes in sensation
□yes □no Tingling
□yes □no Bleeding gums

HEAD:

□yes □no Headache
□yes □no History of head contusions
□yes □no Hearing
□yes □no Auditory problems
□yes □no Dizziness
□yes □no Ear buzzing
□yes □no Sinus (stuffy nose)
□yes □no Ear pain
□yes □no Dental problems
□yes □no Metal implants

CARDIOLOGY/PULMONARY:

□yes □no Chest pain
□yes □no Palpitations
□yes □no Murmur
□yes □no Swollen feet legs worse end of the day
□yes □no Cough
□yes □no Wheezing
□yes □no Shortness of breath walking up one-flight of stairs.

GASTROINTESTINAL:

□yes □no Digestion problems
□yes □no Bloating
□yes □no Nausea
□yes □no Heartburns
□yes □no Vomiting
□yes □no Constipation
□yes □no Unexplained diarrheas
□yes □no Abdominal pain
□yes □no Sour mouth sensation after sleeping.

GENITAL/URINARY:

□yes □no Difficulty urinating
□yes □no Urge urinating
□yes □no Pain urinating
□yes □no Painful intercourse
□yes □no Vaginal secretions
□yes □no Bladder incontinence
□yes □no Kidney stones
□yes □no Kidney infections

MUSCULAR/SKELETAL:

□yes □no Diffuse muscle aching
□yes □no Fibromyalgia
□yes □no Legs or joint swelling
□yes □no Stiffness
□yes □no Painful foot/sole or arch "*first steps in the morning*".

SKIN/HAIR:

□yes □no Changes in skin moles
□yes □no Non-healing ulcers
□yes □no Dry skin
□yes □no Itching
□yes □no Nail fungus

ENDOCRINE/HEMATOLOGICAL/ IMMUNE:

□yes □no HIV positive
□yes □no Hepatitis
□yes □no Fainting
□yes □no Swollen armpit
□yes □no Swollen groin glands,
□yes □no Pale color
□yes □no Bleeding disorders
□yes □no Recurrent infections

Recent Imaging Studies Within The Past Year: (check all that apply and add information if known)

X-rays of my low back ☐ when:_____ where: _____

CTs of my low back ☐ when:_____ where: _____

MRIs of my low back ☐ when:_____ where: _____

Myelogram of low back ☐ when:_____ where: _____

Physicians I have seen for my low back problem:

(fill in applicable information)

	Name	Phone Number	City Located In
Primary care provider:	_____	_____	_____
Chiropractor:	_____	_____	_____
Neurologist:	_____	_____	_____
Pain Medicine Specialist:	_____	_____	_____
Orthopedic Surgeon:	_____	_____	_____
Neurosurgeon:	_____	_____	_____