

Back Evaluation

Central States Orthopedic Specialists
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Patient's Name: Middle: Last Name:

Occupation:

Age:

How long have you had the present pain?

WEEKS

MONTHS

YEARS

How long have you had any trouble with your back, legs, or neck?

WEEKS

MONTHS

YEARS

How long have you been off work or unable to do normal housework?

WEEKS

MONTHS

YEARS

Did your pain begin (check one):



Gradually



Suddenly



From an Injury



At Work

Is your pain (check one):



Continuous



Off and On



Neither

My pain is (Please Check Appropriate Answer):

Better

Worse

Unchanged

WITH COUGH OR SNEEZE



SITTING DOWN AT A TABLE



BENDING FORWARD TO BRUSH TEETH



WALKING SHORT DISTANCE



LYING FLAT ON BACK



LYING FLAT ON STOMACH



LYING ON SIDE WITH KNEES BENT



WHEN I AWAKE IN THE MORNING



MID-MORNING



MIDDLE OF THE NIGHT



My back sometimes gets "stuck" when I bend forward.

Yes No

My back feels it is likely to give way when I bend forward.

Yes No

My pain stops me after I walk a certain distance.

Yes No

After walking, bending forward improves my pain.

Yes No

How many times have you been in a hospital for back, leg, or neck problems?

Have you had previous back surgeries?

Yes No

Type?

Have you had other types of surgeries?

Yes No

Type?

Have any treatments made your pain better?

Yes No

What Treatments?

Have any treatments made your pain worse?

Yes No

What Treatments?

What is the most aggravating thing about your pain?

Additional Comments