Spine – Self Assessment

Mr. Greg Etherington

NAME: _____ DATE: _____

Your problem relates to:

Low back O Upper back O Neck O Right leg O Left leg O Right arm/hand O Left arm/hand O

When did your problem start? _____

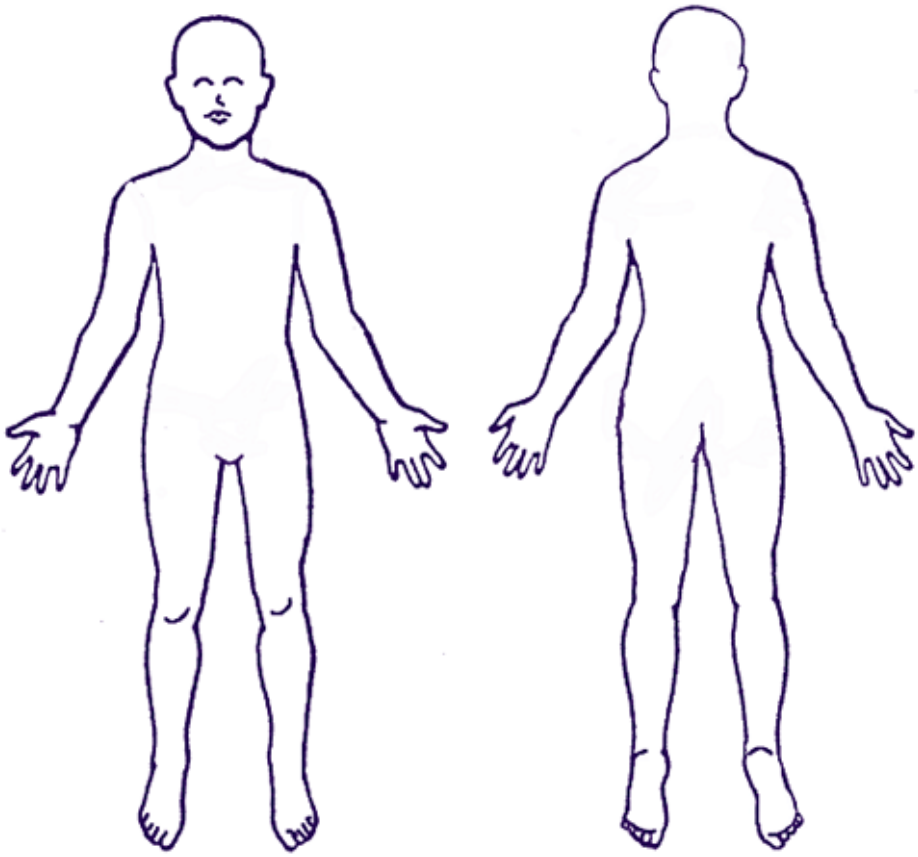
Please describe how your problem started:

Using the front and back drawings, mark the areas in your body where you feel the sensations described below using the appropriate abbreviation. Include all affected areas.

Pain/Aching – **P** Pins & Needles – **X** Numbness – **N**

FRONT LEFT/LEFT **BACK**

RIGHT

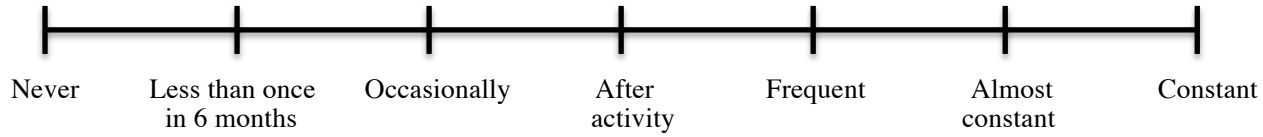


RIGHT

FRONT LEFT/LEFT **BACK**

Name: _____

Please indicate HOW OFTEN you experience pain on the chart below:



Please indicate HOW BAD is your *CURRENT* pain level on the chart below:

What makes your pain worse (tick **YES** or **NO**)

	YES	NO
Walking	O	O
Changing positions	O	O
Coughing or sneezing	O	O
Sitting	O	O
Standing	O	O
During the night	O	O

For your spine problem, have you seen any of the following?

	YES	NO	If **yes**, please provide their name & their advice.
General Practitioner	O	O	_____
Neurologist	O	O	_____
Orthopaedic surgeon	O	O	_____
Neurosurgeon	O	O	_____
Insurance Doctor	O	O	_____
Physiotherapist	O	O	_____
Chiropractor	O	O	_____

What treatment (if any) have you had?

Hospital	O	Home	O	Surgery	O	Traction	O	Physiotherapy	O
Tablets	O	Injections	O	Acupuncture	O	Brace	O	Chiropractor	O
Corset	O	Manipulation under anaesthetic			O	No treatment	O		

Name: _____

Have you HAD or do you HAVE	YES	NO	If yes, what is the problem and who manages it and what treatment (if any) are you on?
High blood pressure	O	O	
Diabetes	O	O	
Heart disease	O	O	
Lung disease	O	O	
Depression	O	O	
Cancer	O	O	
Rheumatoid arthritis	O	O	
Ulcers or stomach disease	O	O	
Kidney disease	O	O	
Liver disease	O	O	
Blood vessel disease (like aortic aneurysm or peripheral vascular disease	O	O	
Ohers?	O	O	

Past Surgical History – please provide a list of operations with the date, that you may have had.

Regular medications: _____

Do you have any allergies? **Yes** O **No** O

If yes, please provide details: _____

Do you have a family history of: Diabetes O Spinal disorders O any other problems O If yes, please list: