Low Back/Hip/Leg Complaints

Today’s Date: ____/____/_____  Name:_________________________________________________

Circle the areas on your body where you feel the described sensations, and mark with the appropriate letter(s).

For Office Use Only:

PAIN = P

NUMBNESS = N

TINGLES = T

Quality

1.) Reports
☐ Weakness left arm  ☐ Weakness left leg  ☐ Fever  EXPLAIN__________________________
☐ Weakness right arm  ☐ Weakness right leg  ☐ Sexual dysfunction  __________________________________
☐ Weakness both arms  ☐ Weakness both legs  ____________________________________________
☐ Bowel dysfunction  ☐ Bladder dysfunction  ____________________________________________

2.) Denies
☐ Weakness  ☐ Bowel dysfunction  ☐ Fever  EXPLAIN__________________________
☐ Sexual dysfunction  ☐ Bladder dysfunction  ____________________________________________

3.) Overall Status
Describe how your pain has changed recently.
☐ No change  ☐ Feels better  ☐ Feels worse  ☐ Requiring more medication

4.) Is this a similar or recurrent problem?
☐ Deny previous episodes  ☐ Recurrent problem for ____________________________  ☐ Similar to previous_____________________

5.) Please circle the number which best describes your pain level, or if the pain varies, list a range (0-No Pain and 10-Worst Pain):
0 1 2 3 4 5 6 7 8 9 10 or Range:___________________________________________________________

6.) Sensations
☐ Aching  ☐ Burning  ☐ Cramping  ☐ Dullness  ☐ Throbbing  ☐ Feeling Asleep
☐ Heaviness  ☐ Numbness  ☐ Pins/Needles  ☐ Sharpness  ☐ Tingling  ☐ Other________________________

Name:_________________________________________________  Date:_____________________

KPI - Low Back Hip Leg Complaints/revised 08/12vy
Duration
7.) How long have you had this current episode or symptoms? _______________________________________________
   How did it begin? ________________________________________________________________

Timing
8.) What activities or positions RELIEVE or DECREASE your pain?
   ☐ Nothing ☐ Bending Backward ☐ Heating Pad ☐ Lying on Side ☐ Resting
   ☐ Movement ☐ Back Brace ☐ Hot Bath/Shower ☐ Sitting ☐ Walking
   ☐ Bending/Stooping ☐ Cold Packs ☐ Lying on Stomach ☐ Standing ☐ Lying on Back
   ☐ Other, describe: ________________________________________________________________

9.) What activities or positions INCREASE your pain?
   ☐ Nothing ☐ Bending Backward ☐ Lying on Back ☐ Lifting ☐ Standing
   ☐ Movement ☐ Back Brace ☐ Heating Pad ☐ Lying on Side ☐ Resting
   ☐ Bending/Stooping ☐ Cold Packs ☐ Hot Bath/Shower ☐ Sitting ☐ Walking
   ☐ Cough/sneeze ☐ Lying on Stomach ☐ Straining w/ Bowel Movement ☐ Twisting
   ☐ Other, describe: ________________________________________________________________

Previous Treatment
10.) Which of these treatments have improved your condition?
    ☐ Back Brace ☐ Bed Rest ☐ Chiropractic ☐ TENS/e-stim ☐ Exercise ☐ Facet Injection
    ☐ Meds OTC ☐ Pain Meds ☐ Steroid Meds ☐ Musc. Relaxers ☐ Neurontin, Lyrica ☐ Epidural Injection
    ☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Sacroiliac Injection
    ☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Steroid Injection
    ☐ Restrict Activity ☐ Other ________________________________________________________

11.) Which of these treatments did not improve your condition?
    ☐ Back Brace ☐ Bed Rest ☐ Chiropractic ☐ TENS/e-stim ☐ Exercise ☐ Facet Injection
    ☐ Meds OTC ☐ Pain Meds ☐ Steroid Meds ☐ Musc. Relaxers ☐ Neurontin, Lyrica ☐ Epidural Injection
    ☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Sacroiliac Injection
    ☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Steroid Injection
    ☐ Restrict Activity ☐ Other ________________________________________________________

12.) Which of these treatments are you currently receiving?
    ☐ Back Brace ☐ Bed Rest ☐ Chiropractic ☐ TENS/e-stim ☐ Exercise ☐ Facet Injection
    ☐ Meds OTC ☐ Pain Meds ☐ Steroid Meds ☐ Musc. Relaxers ☐ Neurontin, Lyrica ☐ Epidural Injection
    ☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Sacroiliac Injection
    ☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Steroid Injection
    ☐ Restrict Activity ☐ Other ________________________________________________________

13.) Who were you previously treated by?
    ☐ N/A ☐ Neurosurgeon ☐ Orthopedic Surgeon ☐ Chiropractor
    ☐ This Office ☐ Orthopedic Surgeon ☐ Pain Clinic ☐ Other

When was your most recent MRI, CT, or XRAY of problem area?
   ________________________________
Where was it performed?
   _____________________________________________________________

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Which of these treatments have not been attempted or prescribed?
    ☐ Back Brace ☐ Bed Rest ☐ Chiropractic ☐ TENS/e-stim ☐ Exercise ☐ Facet Injection
    ☐ Meds OTC ☐ Pain Meds ☐ Steroid Meds ☐ Musc. Relaxers ☐ Neurontin, Lyrica ☐ Epidural Injection
    ☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Sacroiliac Injection
    ☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Steroid Injection
    ☐ Restrict Activity ☐ Other ________________________________________________________