Mid Back 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__________________________
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 Neck Backward ☐ Heating Pad ☐ Raising Arms Up ☐ Resting
☐ Any Movement ☐ Cervical Collar ☐ Hot Bath/Shower ☐ Sitting ☐ Turning Head
☐ Bending Neck Forward ☐ Cold Packs ☐ Lying on Back ☐ Standing
☐ Other, describe: ____________________________________________________________

9.) What activities or positions INCREASE your pain?
☐ Nothing ☐ Bending Neck Backward ☐ Extreme of Motion ☐ Lifting ☐ Standing
☐ Movement ☐ Cervical Collar ☐ Hot Bath/Shower ☐ Lying on Back ☐ Turning Head
☐ Bending Neck Forward ☐ Cold Packs ☐ Lying on Back ☐ Sitting ☐ Bend/Stoop
☐ Inspiration ☐ Cough/sneeze ☐ Straining w/ Bowel Movement
☐ Other ____________________________________________________________

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 ☐ Neuoptin, Lyrica ☐ Epidural Injection
☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Steroid Injection
☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ 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 ☐ Neuoptin, Lyrica ☐ Epidural Injection
☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Steroid Injection
☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ 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 ☐ Neuoptin, Lyrica ☐ Epidural Injection
☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Steroid Injection
☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Restrict Activity
☐ Other ____________________________________________________________

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

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

Office use only:
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 ☐ Neuoptin, Lyrica ☐ Epidural Injection
☐ Phys Therapy ☐ Occ. Therapy ☐ Ultrasound ☐ Rhizotomy ☐ Traction ☐ Steroid Injection
☐ Spinal Decomp. Therapy ☐ NSAIDs ☐ Heat ☐ Cold Pack ☐ Restrict Activity
☐ Other ____________________________________________________________

KPI - Mid Back Rib Chest Complaints/revised 08/12vy