



River Oaks Pain Management

“Compassionate Physicians for Complex Problems”

BACK PAIN

CHECK THE FOLLOWING:

- Do you have mid back pain _____
- Do you have low back pain _____
- Do you have back and leg pain _____

THE PAIN RADIATES TO:

- The ___left ___right bilateral abdomen
- The ___left ___right both buttocks
- The ___left ___right both hips
- The ___left ___right both thighs
- The ___left ___right both knees
- The ___left ___right both calves
- The ___left ___right both feet

THE ONSET OF THE PAIN HAS BEEN:

- Within the last three days _____
- Within the last three weeks _____
- Within the last three months _____
- Within the last year _____
- Within the last one or two years _____
- Within the last two or three years _____
- Within the last three or four years _____
- Within the last four or five years _____
- Over the last five years _____
- Over the last ten years _____

HAVE YOU CONSULTED WITH:

- An orthopedic surgeon _____
- A neurosurgeon _____
- A GI specialist _____

HAVE YOU SUCCESSFULLY GAINED RELIEF WITH:

- A Spinal Cord Stimulator _____ Not Tried_____
- Injections _____ Not Tried_____
- Surgery _____ Not Tried_____
- Ice _____ Not Tried_____
- Heat _____ Not Tried_____

- Hypnosis _____ Not Tried_____
- A TENS unit _____ Not Tried_____
- Acupuncture _____ Not Tried_____
- Bio-feedback _____ Not Tried_____
- Chiropractic care _____ Not Tried_____
- Physical therapy for at least four weeks _____ Not Tried_____
- Over the counter medications _____ Not Tried_____
- Prescription medications _____ Not Tried_____
- Lying down _____ Not Tried_____
- Elevating Legs _____ Not Tried_____

THE PAIN BEGAN:

- While exercising _____
- At work _____
- When hit by an object _____
- After bending _____
- After falling _____
- After lifting _____
- After an MVA _____
- After pushing a heavy object _____
- After repetitive motion _____
- After twisting _____
- While walking _____
- After eating _____
- After surgery _____

DESCRIBE THE PAIN:

- Deep _____
- Tingling _____
- Aching _____
- Burning _____
- Dull _____
- Pressure _____
- Sharp _____
- Shooting _____
- Throbbing _____
- Numbness _____

THE PAIN IS:

- Constant, with periods of increasing pain _____
- Constant, with no changes in the intensity of the pain _____
- Pain that is episodic only, with periods that are pain free _____

WHAT ARE SOME OF YOUR SYMPTOMS:

- Hot and cold skin changes _____
- Sensitivity to light touch _____
- Joint pain _____
- Redness _____
- Tingling _____
- Numbness _____
- Shiny skin _____
- Swelling _____
- Pain after meals _____
- Diarrhea _____
- Constipation _____

WHAT AGGRAVATES THE PAIN:

- Walking _____
- Right bending _____
- Left bending _____
- Extension _____
- Flexion _____
- Coughing, sneezing, or riding for extended periods _____
- Cold _____
- Heat _____
- Light or sound _____
- Eating _____
- Sitting _____
- Medication _____
- Activity _____
- Standing _____
- Lifting _____
- Weather _____

PRESENTLY YOUR DAILY ACTIVITY INCLUDES:

- Lifting less than 10 lbs _____
- Lifting between 10 to 20 lbs _____
- Lifting between 20 to 50 lbs _____
- Lifting greater than 50 lbs _____
- Primarily sitting _____
- Standing for extended periods of time _____
- Repetitive bending _____
- Repetitive arm motion _____