REDDING
SPINE & SPORTS
MEDICINE

NAME: _____

DATE: _____

Describe any symptom changes since your last visit.
_____
_____
_____
_____

What makes your symptoms:
Worse: _____
Better: _____
_____

_____
Since your last visit, are you:
_____**Better by** _____**%**
_____**Worse by** _____**%**
_____**Same**
_____

Circle the number that best describes your current pain with "10" ***being the most severe*****.**

NECK/ARM	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
BACK/LEG	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

How long/far can you:
Sit _____ **Stand** _____ **Walk** _____

If you are taking medications, please list (include dosage):
_____
_____
_____

Have you had any medical testing since your last visit?
No _____ **Yes** _____ **(Please list)**
_____
_____

Have you seen any other physicians since you last visit?
No _____ **Yes** _____

(If yes, who and for what reason?)
_____
_____

Are you currently working? Yes ___ **No** ___
Any work restrictions?_____

If you have had an injection since your last visit, how would you rate your satisfaction (circle one)?

1. **Not at all satisfied**
2. **Not very satisfied**
3. **Neither satisfied nor dissatisfied**
4. **Mostly satisfied**
5. **Very satisfied**

Are you in Physical Therapy? Yes ___ **No**

If yes, date of last visit?

Are you doing a home exercise program?
Yes ___ **No** ___
If yes, how often?

PAIN DIAGRAM

Please mark the areas on the diagram using the appropriate symbols. These symbols describe what you feel.

Numbness	**Pins & Needles**	**Burning**	**Stabbing/Sharp**	**Aching**
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