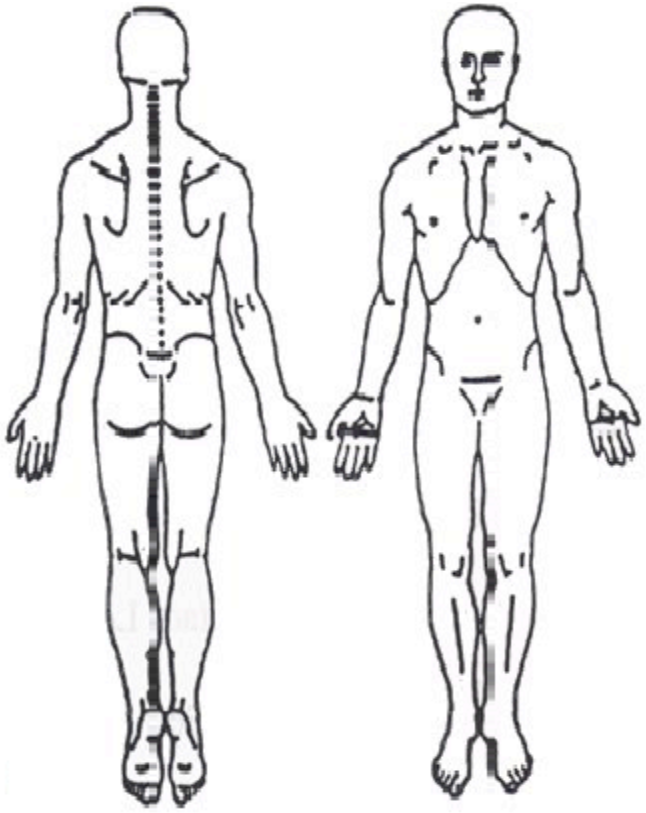
VIRGINIA
SPINE & SPORTS ORTHOPAEDICS
A Division of Centers for Advances Orthopaedics, LLC

Patient name: _____ Date: _____



Location and type of pain:
Please mark diagram below

Numbness:
- - - - - - - - - -
- - - - - - - - - -

Pins/needles:
x x x x x x x x
x x x x x x x x

Burning:
/ / / / / / / /
/ / / / / / / /

Pain:
o o o o o
o o o o o

Stabbing:
+ + + + + +
+ + + + + +

How often is your pain? __ Constantly __ Intermittently : Onset? __ Sudden __ Gradual

Please rate your pain score (using a scale of 0 to 10, 0 = no pain and 10 =unbearable pain)
_____ Pain scale _____ Without Activity _____With Activity

What makes the pain better? (e.g. heat, cold, sitting, laying down, meds)
_____

What makes the pain worse? (e.g. bending, lifting, standing)
_____

Have you taken part in any conservative treatment for current problem?
□Physical Therapy □Chiropractor □Meds □Injections □Massage

Did conservative measures help □Yes □No

Please list any health care professionals who have treated you for this specific problem in the past: _____