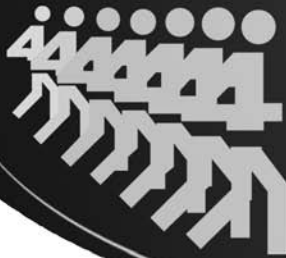


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**BAHRI ORTHOPEDICS
 & SPORTS MEDICINE
 CLINIC, P.A.**

Patient with Chronic Low Back Pain (Drawing of Patient's Pain)

(1 of 2)

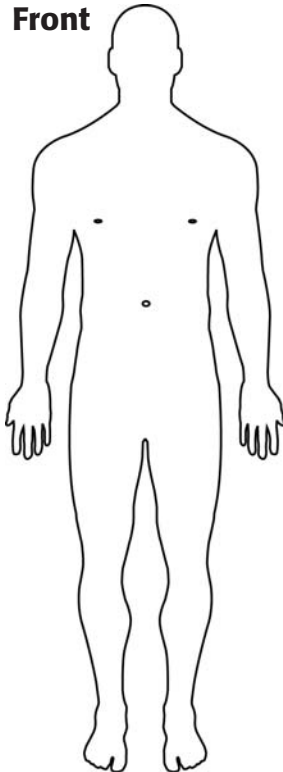
Created 05/12/2009

Please Give This Paper to the Doctor at the Time of Examination.

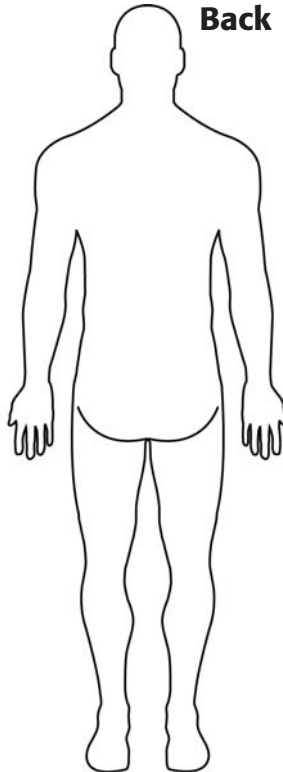
Name: _____ Date: _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. To complete the picture ... please draw in your face.

Front



Back



If it applies:

Balance of pain in arm(s):

- most
- some
- none

Balance of pain in leg(s):

- most
- some
- none

^ ^ ^ ^
 ^ ^ ^ ^
 ^ ^ ^ ^

ACHE

= = = =
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 = = = =

NUMBNESS

O O O O
 O O O O
 O O O O

**PINS &
NEEDLES**

X X X X
 X X X X
 X X X X

BURNING

/ / / /
 / / / /
 / / / /

STABBING

Please take the time to fill out the appropriate places.

Created 05/12/2009

Name: _____ Age: _____

Present Job: _____ How Long: _____

Last Job: _____

1) On what date (roughly at least) did you present pain start? _____

2) How long have you had any problems with back, neck, or legs? _____

3) How long have you been unable to work or do normal housework? _____

4) Did your pain start: gradually suddenly injury _____
Where? _____

5) Do you get short of breath or a tight feeling in your chest with your back pain? _____

6) Do you notice your pain after you exercise or exert yourself? _____

7) Does your pain ever radiate down your left arm or elsewhere? Please describe _____

8) If sudden onset, please describe what happened. _____

9) My pain occurs when I (check appropriate box):

- | | | | |
|-----------------------------------|---------------------------------|--------------------------------|--|
| Cough or sneeze | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Sit in a straight chair | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Sit in a soft easy chair | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Bend forward to brush teeth | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Walk up stairs | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Walk down stairs | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Lie flat on my back | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Lie flat on my stomach | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |
| Lie on my side with my knees bent | <input type="checkbox"/> Better | <input type="checkbox"/> Worse | <input type="checkbox"/> No Difference |

10) My back sometimes gets stuck when I bend forward. Yes No

After walking, bending forward relieves my pain. Yes No

My back feels like giving way when I bend forward. Yes No

My pain stops me when I walk a certain distance. Yes No

11) Have you been in a hospital for back, leg, or neck pain? Yes No

Number of times: _____ Please give dates: _____

12) Have you had myelograms taken? Yes No

Number of times: _____

13) Have you had neck or back surgery? Yes No

Number of times: _____ Please give type and dates: _____

14) Have you been in a hospital with other medical problems? Yes No

Number of times: _____ Please describe: _____

15) What treatments have made your pain better? _____

What treatments have made your pain worse? _____

16) What made you come to this office? _____

17) Do you have an attorney helping you? Yes No

18) Do other members of your family have significant back trouble? Yes No

Who: _____

19) Do you have to change jobs? Yes No

To what? _____

20) Are you under pressure at home? Yes No At Work? Yes No

Mild Moderate Severe

21) What is the most aggravating thing about your pain? _____

22) What was the date of your last physical exam and the name of the doctor who did it? _____

_____ Pelvic Done? Yes No

_____ Rectal Done? Yes No