

# ORTHOPAEDIC SPECIALTY GROUP, PC

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE MARK THE LEVEL OF PAIN WITH AN "X"**

How bad is your **BACK** pain now ? (1 being No PAIN, 10 being Worst Possible)

1            2            3            4            5            6            7            8            9            10

How bad is your **LEG** pain now ? (1 being No PAIN, 10 being Worst Possible)

1            2            3            4            5            6            7            8            9            10

How bad is your **NECK** pain now ? (1 being No PAIN, 10 being Worst Possible)

1            2            3            4            5            6            7            8            9            10

How bad is your **ARM** pain now ? (1 being No PAIN, 10 being Worst Possible)

1            2            3            4            5            6            7            8            9            10

**The problem which brought me to the doctor today is:**

- |   |   |   |
|---|---|---|
| 1. <input type="checkbox"/> Low back pain or discomfort | <input type="checkbox"/> Middle back pain or discomfort | <input type="checkbox"/> Abnormal curvature of back                       |
| 2. <input type="checkbox"/> Buttock and/or              | <input type="checkbox"/> Leg pain or discomfort on the  | <input type="checkbox"/> right side or <input type="checkbox"/> left side |
| 3. <input type="checkbox"/> Leg more painful            | <input type="checkbox"/> Back more painful              |   |

**OR:**

- |   |   |  |
|---|---|--|
| 1. <input type="checkbox"/> Neck pain or discomfort       | <input type="checkbox"/> Shoulder pain or discomfort    | <input type="checkbox"/> right side <input type="checkbox"/> left side |
| 2. <input type="checkbox"/> Upper back pain or discomfort | <input type="checkbox"/> Arm/hand pain or discomfort on | <input type="checkbox"/> right side <input type="checkbox"/> left side |
| 3. <input type="checkbox"/> Neck more painful             | <input type="checkbox"/> Shoulder more painful          | <input type="checkbox"/> Arm more painful                              |

**PLEASE DRAW THE DISCOMFORT PATTERN BELOW:**

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.  
Mark the areas of radiation. Include all affected areas:

	Right	<b>FRONT</b>	Left		Left	<b>BACK</b>	Right
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ACHE = ^^^^^^^

NUMBNESS = \* \* \* \* \*

PINS/NEEDLES = = = = =

BURNING = XXXXXX

STABBING = // // // //