

ASSOCIATED NEUROLOGICAL SPECIALTIES

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Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

CHIEF COMPLAINT-LOWER BACK PAIN

1. How long have you had lower back pain?
  
2. Was there an injury? \_\_\_\_\_ When? \_\_\_\_\_
  
3. Is the pain one-sided or both sides? Which side?
  
4. Does the pain go below the knees?
  
5. Does the pain go to the feet?
  
6. If the pain goes to the feet, is there numbness and tingling and which side of the foot is involved?
  
  
7. Do the muscles jump under the skin? \_\_\_\_\_ Where?
  
8. Is there any weakness in the leg? \_\_\_\_\_ Where?
  
9. Do you have any loss of bowel or bladder control? Which?
  
10. IS the pain worse whe sitting, standing, or lying down? Which?
  
11. Is the pain less when you get up out of sleep in the morning, or is it worse?
  
12. If you cough or sneeze, does this send pain down your leg?

CHIEF COMPLAINT-LOWER BACK PAIN CONTINUED:

13. Have you had similar pain in the past? \_\_\_\_\_ If so, what worked for the pain then?

14. Have you had any diagnostic studies? \_\_\_\_\_ If so, what?

A. MRI scan of lumbar spine? \_\_\_\_\_ If so, when and where?

B. An electromyogram (EMG) of the legs? \_\_\_\_\_ If so, when and where?

15. What did the above studies show?

16. What medications have you taken for the pain? Did it work?

17. Do you engage in any sports? \_\_\_\_\_ If so, does it seem to make the pain worse?

18. Have you done any new activity or sports?