ATHLETIC ORTHOPEDICS & KNEE CENTER
FOOT • ANKLE • HAND • PAIN • SHOULDER • SPINE

Spine Form

Name: _____

Date: M M / D D / Y Y Y Y

IDENTIFYING THE PAIN

Describe the mechanism of injury/problem

Ankle	❑ L	❑ R	Calf	❑ L	❑ R
Cervical Spine	❑ L	❑ R	Chest/Sternum	❑ L	❑ R
Coccyx	❑ L	❑ R	Elbow	❑ L	❑ R
Hip	❑ L	❑ R	Lower Back	❑ L	❑ R
Ribs	❑ L	❑ R	Sacrum	❑ L	❑ R
Upper Back	❑ L	❑ R	Other: _____		

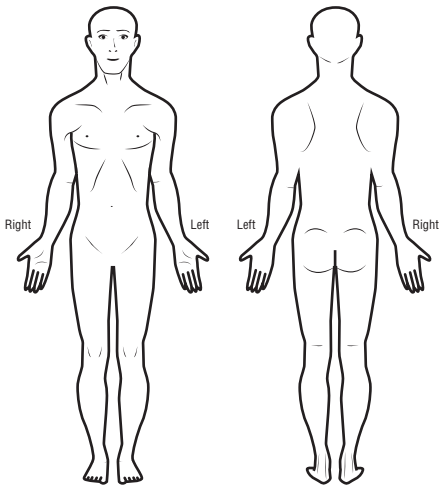
❑ Bilateral (Both Sides) ❑ Anterior (Front) ❑ Posterior (Back)
❑ Medial (Inner) ❑ Lateral (Outer)

Please indicate the problem area with the following:

XXXX Sharp Pain

//// Dull Ache

---- Numbness or Tingling



CONTEXT

❑ Cannot Identify ❑ Fall
❑ Bending ❑ Lifting
❑ Twisting ❑ Sports Injury
❑ Work Injury ❑ Car Accident
❑ Assault ❑ Overuse
❑ Laceration ❑ Heard a Pop
❑ Other: _____

SEVERITY

❑ No Pain ❑ Mild ❑ Moderate ❑ Severe

Pain Level(circle one): NONE 0 1 2 3 4 5 6 7 8 9 EXTREME 10

ASSOCIATED SYMPTOMS

❑ Weakness ❑ Numbness
❑ Tingling ❑ Swelling
❑ Redness ❑ Warmth
❑ Bruising ❑ Catching/Locking
❑ Popping/Clicking ❑ Buckling
❑ Grinding ❑ Instability
❑ Drainage ❑ Fever
❑ Weight Loss ❑ Radiating Pain
❑ Change in Bowel/Bladder Habits
❑ Other: _____

ALLEVIATING FACTORS

❑ Nothing Helps ❑ Ice
❑ Rest ❑ Elevation
❑ Exercise ❑ Stretching
❑ PT/OT ❑ NSAIDs
❑ Orthotics ❑ Brace
❑ Previous Surgery ❑ Sling
❑ Limited Weightbearing
❑ Chiropractic Care ❑ Narcotics
❑ Epidural Steroid Injection
❑ Over-the-counter Medication
❑ Cortisone Injection
❑ Viscosupplementation Injection
❑ Other: _____

AGGREVATING FACTORS

❑ Cannot Identify ❑ Lifting
❑ Carrying ❑ Twisting
❑ Pushing/Pulling ❑ Gripping
❑ Grasping ❑ Squeezing
❑ Throwing ❑ Range of Motion
❑ Weightbearing ❑ Exercise
❑ Previous Surgery ❑ Computer Use
❑ Changing Clothes ❑ Getting Out of Bed
❑ Going from Sit to Stand
❑ Morning ❑ Daytime
❑ Nighttime ❑ Cold Weather
❑ Damp Weather ❑ Driving
❑ Other: _____

HISTORY

Arthritis/Musculoskeletal Problems	❑ Self	❑ Family	Congenital Abnormalities	❑ Self	❑ Family	Cancer	❑ Self	❑ Family
Cerebral/Seizure Problems	❑ Self	❑ Family	Heart Problems	❑ Self	❑ Family	Diabetes	❑ Self	❑ Family
Renal/Urinary Tract Problems	❑ Self	❑ Family	Psychiatric Problems	❑ Self	❑ Family			

PRIOR RELATED INCIDENCES

Prior Treatment ❑ None ❑ Yes	Prior Diagnosis & Treatment	Treatment Date M M / D D / Y Y Y Y
Prior Related Surgery ❑ None ❑ Yes	Procedure Type	Procedure Date M M / D D / Y Y Y Y
Prior Imaging (Past 3 Months) ❑ None ❑ Yes	Imaging Type ❑ X-Ray ❑ MRI ❑ Other: _____	Imaging Date M M / D D / Y Y Y Y
Previous Injections ❑ None ❑ Yes	Injection Type	Injection Date M M / D D / Y Y Y Y
❑ Injections Did Not Help ❑ Injections Helped a Little ❑ Injections Helped Temporarily ❑ Injections Helped Significantly		
Previous Therapy ❑ None ❑ Yes	Therapy Type	Therapy Date M M / D D / Y Y Y Y
❑ Therapy Did Not Help ❑ Therapy Helped a Little ❑ Therapy Helped Temporarily ❑ Therapy Helped Significantly		

Reset
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9180 Katy Freeway, Suite 200 • Houston, TX 77055 • 713.984.1400 • fax: 713.984.0544 • www.aokc.net