FOR DR. HODGES BACK & NECK PATIENTS ONLY

PATIENT PAIN DRAWING

Date:_____ Age:_____

Name:_____ Sex: M F

Weight:_____lbs

Height:_____ft_____in

Occupation:_____

_____

yrs _____

Employer_____

Marital Status. (circle one)
Single
Divorced
Widowed
Separated
Married

Spouse's name:_____

# of children:_____

Tobacco use: Yes No

What?_____

# of years:_____

Alcohol Use: Yes No

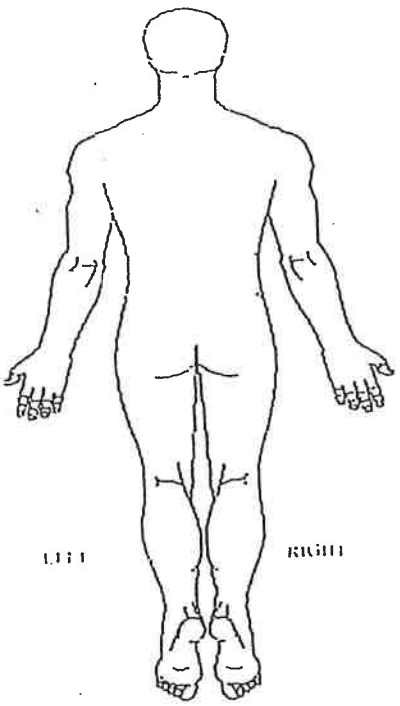
What?_____

# of years._____

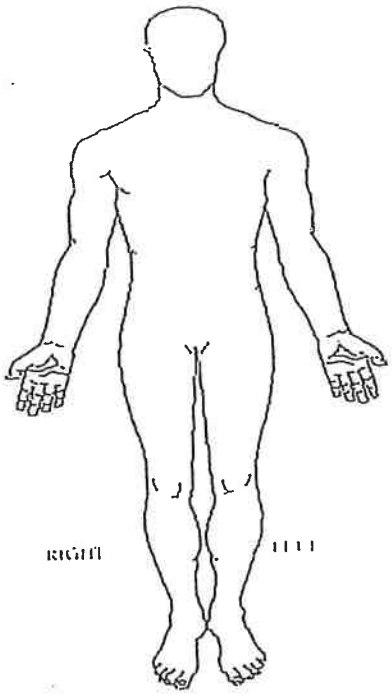
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all afftected areas. Just to complete the picture, please draw in you face

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔ	= = =	° ° °	xxx	///	° ° °

Back



Front



Have you seen Dr. Hodges before? Yes_____ No_____

Did you injure yourself at work? Yes____ No ____ Date of Injury_____

If yes, whate date did you last work?_____ full-duty_____ light-duty_____

Are you currently working now? Yes___ No___ full-duty_____ light-duty

Have you had any previous back or neck problems prior to this injury? Yes ___ No___

Pain:

When did you pain begin?_____

How did you get injured?_____

_____

What makes it worse?_____

What makes it better?_____

Does coughing or sneezing make it worse? Yes ____ No____

Any change in bowel or bladder habits? Yes____ No____

Any sexual dysfunction? Yes____ No____

Circle Answers:

Which is worse, back pain or neck pain?_____ Which is worse, back pain or leg pain?_____

Which is worse, leg pain or arm pain?_____ Which worse, neck pain or arm pain?_____

Which is worse, left arm or right arm?_____ Left leg or right leg?_____

TURN PAGE OVER AND ANSWER QUESTIONS ON OTHER SIDE

Do you have leg weakness?

If yes, which leg? Left Right

Do you have leg numbness?

If yes, which leg? Left Right

Do you have arm weakness?

If yes, which arm? Left Right

Do you have arm numbness?

If yes, which arm? Left Right

Have you had an epidural block or steroid injection? Yes No

If yes, which Doctor performed the block? _____

How long did you get relief from block? _____

Have you ever seen a Chiropractor? Yes No

Have you ever seen a Psychiatrist? Yes No

Have any physical therapy? Yes No

If yes, please mark which treatments you have had?

TENS UNIT HEAT ULTRASOUND POOL THERAPY
EXERCISE TRACTION MASSAGE

Are you allergic to any medications? Yes No

If yes, please list _____

What type of reaction do you have? _____

Are you allergic to anything else? Yes No

If yes, please list _____

What type of reaction does it cause? _____

Are you in a medication management clinic with another Physician? Yes No

If yes, which Physician? _____

Have you had any previous neck or back surgery? Yes No

Date of Surgery and Doctors Name _____

Have you had any other major surgeries? Yes No

If yes please list? _____

Please list any major complications after any major surgery performed in the past:

(i.e.) infections, blood clots, lung disorders, nerve damage, bleeding disorders anesthesia sexual dysfunctions)

Signature of Patient _____