

## SPINE TRIAGE FORM

PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CHIEF COMPLAINT:

<u>Neck</u>		<u>Back</u>	
Neck pain alone	( )	Low back and/or buttock pain	( )
Neck and arm pain	( )	Back pain and leg pain	( )
Arm pain alone	( )	Leg pain alone	( )
		Mid back pain	( )

DATE OF ONSET OF PRESENT PAIN: \_\_\_\_\_

WHAT DO YOU THINK CAUSED YOUR PRESENT PAIN? \_\_\_\_\_

INJURY FIRST OCCURRED AT: Work ( ) Motor vehicle accident ( ) Other ( )

Explain: \_\_\_\_\_

HOW LONG HAVE YOU HAD PAIN? Less than 1 week ( ) Less than 4 weeks ( ) 1-3 mos ( ) More than 3 mos ( )

HAVE YOU HAD SIMILAR ATTACKS IN THE PAST? No ( ) 1 or 2 ( ) 2 to 5 ( ) 5 or more ( )

IF YOU HAVE LEG PAIN:

Is the back pain worse than the leg pain?	YES ( )	NO ( )
Is the leg pain worse than the back pain?	YES ( )	NO ( )
Are the leg pain and back pain about equal?	YES ( )	NO ( )

IF YOU HAVE ARM PAIN:

Is the neck pain worse than the arm pain?	YES ( )	NO ( )
Is the arm pain worse than the neck pain?	YES ( )	NO ( )
Are the arm pain and neck pain about equal?	YES ( )	NO ( )

DO YOU HAVE NUMBNESS, PINS AND NEEDLES OR A TINGLING SENSATION?

In the foot/leg/thigh (circle)	YES ( )	NO ( )
In the hand/forearm/fingers (circle)	YES ( )	NO ( )

DO YOU HAVE DIFFICULTY PASSING URINE? YES ( ) NO ( )

IS THE PAIN:

Bad all the time and unrelieved by rest?	YES ( )	NO ( )
Awakening you at night?	YES ( )	NO ( )
Worse after activities?	YES ( )	NO ( )
Worse after sitting?	YES ( )	NO ( )
Increased with a bowel movement?	YES ( )	NO ( )
Worse with coughing/sneezing?	YES ( )	NO ( )

ANY OTHER SYMPTOMS YOU FEEL RELATED BUT NOT DESCRIBED? YES ( ) NO ( )

IS THERE ANYTHING YOU HAVE DONE TO MAKE THE PAIN BETTER? YES ( ) NO ( )

If yes, explain: \_\_\_\_\_

HAVE YOU HAD PREVIOUS BACK/NECK TREATMENT? YES ( ) NO ( )

Date of treatment \_\_\_\_\_ Results \_\_\_\_\_

DO YOU PARTICIPATE IN ANY SPECIFIC/GENERAL EXERCISE? YES ( ) NO ( )

If yes, explain: \_\_\_\_\_

HAVE YOU BEEN ABLE TO CONTINUE WORK? YES ( ) NO ( )

If not, out of work/modified duty from \_\_\_\_\_ to \_\_\_\_\_

ARE YOU UNDER THE CARE OF A DOCTOR (SPECIALIST)? YES ( ) NO ( )

HAS HE/SHE RECOMMENDED SURGERY? YES ( ) NO ( )

IF NO SURGERY, WHAT WAS THE TREATMENT? Physical Therapy Medications Injections

HAVE YOU ENGAGED THE SERVICES OF AN ATTORNEY? YES ( ) NO ( )

over

## SPINE TRIAGE FORM (continued)

HAVE YOU HAD X-RAYS OF YOUR NECK OR LOW BACK? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD A MYELOGRAM? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD A CT SCAN? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD AN MRI? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD AN EMG? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD EPIDURALS, NERVE OR FACET BLOCKS? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Results, if known \_\_\_\_\_

HAVE YOU HAD PREVIOUS SPINE SURGERY? YES ( ) NO ( )

If yes, Date \_\_\_\_\_ Location \_\_\_\_\_

Type/Level, if known \_\_\_\_\_

RESULTS OF PREVIOUS SURGERY: Worse ( ) Same ( ) Improved ( ) Normal ( )