Orthopaedics of Brevard
830 Executive Lane, Suite 120
Rockledge Florida 32955

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IF YOU ARE HERE FOR BACK, HIP, or NECK PAIN, PLEASE FILL OUT THIS FORM ENTIRELY.
THIS INFORMATION IS NECESSARY FOR THE EVALUATION OF YOUR SPINE PROBLEM.

Name: ____ Date: _________________

Date of Birth: _______________ Please estimate your Height: ________ Weight: _________

Present Occupation: ____________________________________ How long: ______________

Chief Complaint: ____

I feel the pain is (circle all that apply):

Sharp Burning Tingling Tearing Dull Cramping Discomfort Aching Severe

Stiffness Tightness Numbness Weakness Mild Other: ____________________________

Area of Body Injured (circle all applicable): Neck Upper Back Lower Back Arms

Any Previous Problems with the above areas: ___ Yes ___ No

If Yes/Unknown Please Describe: ____

____

Please state how the accident or injury occurred and how you felt (symptoms) immediately after:

____

____

Where is the pain worse (circle one): Arm Shoulder Back Buttock Leg Hip Neck

What makes your pain feel better: ____

What makes your pain feel worse: ____

Since its onset, is the pain getting (circle one): Better Worse Neither

Do you have pain with walking? ___ Yes ___ No How Far? __________________________

Do you have pain at rest? ___ Yes ___ No

Do you lean on the cart at the store? ___ Yes ___ No

Have you noticed any of the following:

	YES	NO
Loss of bowel control	_____	_____
Loss of bladder control	_____	_____
Leg/Arm weakness	_____	_____
Leg/Arm numbness	_____	_____

Patient Name: ____ DOB: ____________________

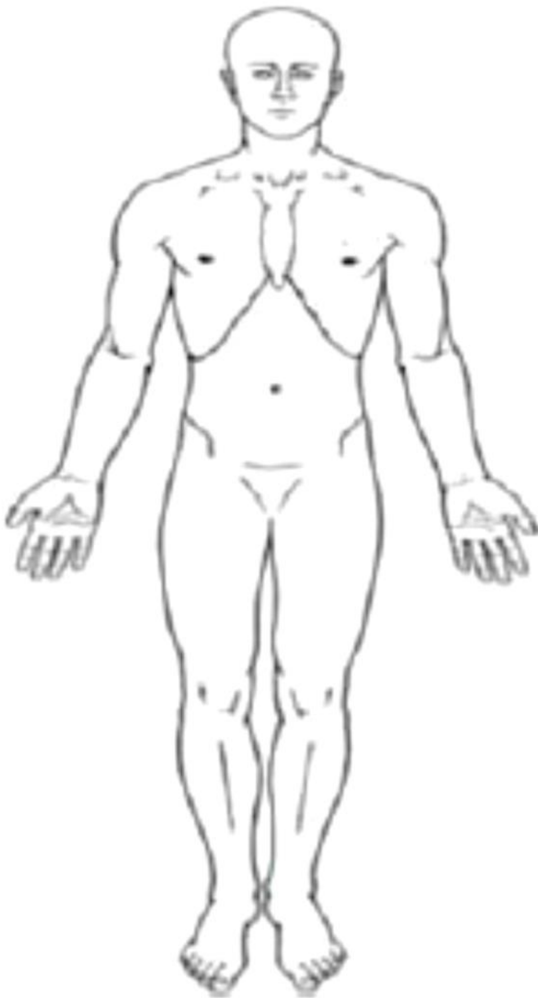
Date: ____________________

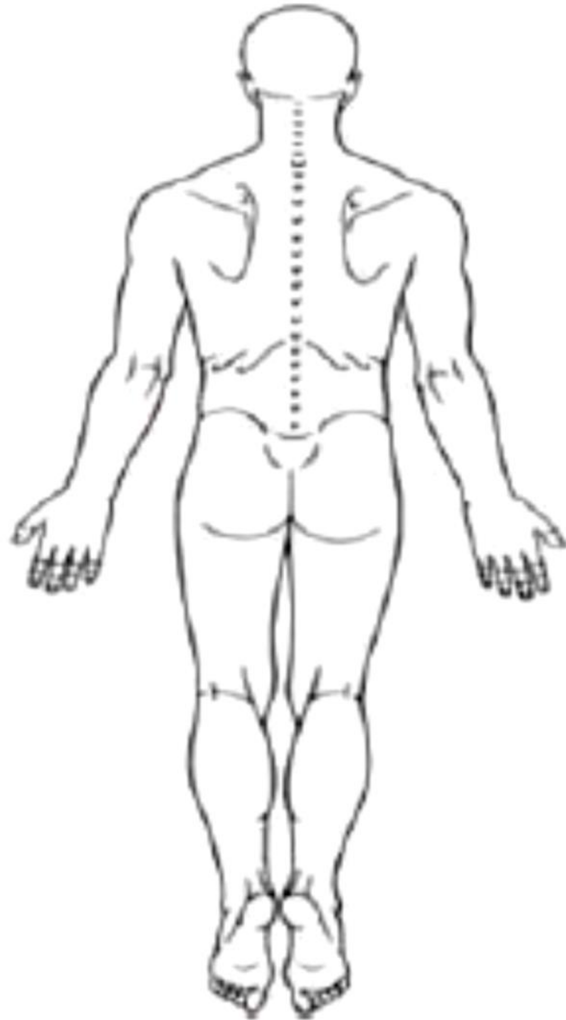
Please mark the area on the diagram where you have
Mark the areas with the following symbols:

Ache: $$$ Numbness: +++ Pins & Needles: XXX Stabbing: /// Burning: ### Shooting:***

FRONT SIDE BACK SIDE

Right Side Left Side Left Side Right Side





How is the pain on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Mild Worst