



SPINE SHEET

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Dr. David Mack
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In order to carefully plan your treatment, your doctor requests the following information prior to evaluation of your spinal problem. Please complete this form prior to your appointment date.

Today's Date _____

Name _____ Age _____ Sex _____ Height _____ Weight _____

Referred by _____ Reason for evaluation _____

Present Occupation _____ How long _____

Are you currently working? Yes _____ No _____ Last worked? _____

How long have you been unable to work or perform normal household work? _____

Primary Problem _____

Date of first episode of pain _____ Injury or accident? No _____ Yes _____

Date of injury _____ Area of body injured? _____

Any back or neck trouble prior to injury? Yes _____ No _____

State in your own words how the accident or injury happened and what you felt at the time (symptoms). If there was not an accident, how and when did the pain start?

When did the most recent episode start? _____

Which pain is worse? Back _____ Leg _____ Neck _____ Arm _____ Shoulder _____

Pain at night? Yes _____ No _____ Pain at rest? Yes _____ No _____

Pain increase with coughing or sneezing? Yes _____ No _____ Weight loss? Yes _____ No _____

PHYSICAL IMPAIRMENT ESTIMATE

If you are currently not able to do your normal working activities due to an injury or illness and require documentation for Workman’s Compensation or insurance, please fill in the following estimates to help your doctor document any physical impairment.

Do you feel you are disabled from your regular work? Yes _____ No _____

In an 8 hour workday, I can

Stand	None _____	1-4 hours _____	4-8 hours _____
Walk	None _____	1-4 hours _____	4-8 hours _____
Sit	None _____	1-4 hours _____	4-8 hours _____
Drive	None _____	1-4 hours _____	4-8 hours _____
Bend	None _____	1-4 hours _____	4-8 hours _____
Squat	None _____	1-4 hours _____	4-8 hours _____
Climb	None _____	1-4 hours _____	4-8 hours _____
Grasping	None _____	1-4 hours _____	4-8 hours _____
Fine manipulation	None _____	1-4 hours _____	4-8 hours _____
Pushing & Pulling	None _____	1-4 hours _____	4-8 hours _____
Lift frequently	None _____	1-4 hours _____	4-8 hours _____
Lift occasionally	None _____	1-4 hours _____	4-8 hours _____

I feel I am able to do:

- _____ Heavy lifting work – no restrictions – lifting over 100 lbs; carrying over 50 lbs.
- _____ Heavy lifting work – Class 1 – lifting up to 100 lbs; carrying up to 50 lbs.

I feel I am restricted to:

- _____ Medium work – 20% reduced capacity – Class 2 - lifting up to 50 lbs; carrying up to 25 lbs.
- _____ Light work – 40% reduced capacity – Class 3 – lifting up to 20 lbs.; carrying up to 10 lbs
- _____ Sedentary work – 60% reduced capacity – Class 4 – lifting up to 10lbs., carrying up to 5 lbs.
- _____ Incapable of minimal activity – 80% - 100% reduced capacity – Class 5

The reason for my limitation is:

- _____ Pain _____
- _____ Paralysis _____
- _____ Deformity _____
- _____ Other _____

Does anything make your pain better? _____ Does anything make your pain worse? _____

How often do you have pain?

- All of the time _____ Everyday _____
- Most of the time _____ Once a week _____
- Some of the time _____ Once a month _____

Is the pain better, the same or worse than 1 month ago? _____

Have you had:	Yes	No
Bowel control changes	_____	_____
Bladder control changes	_____	_____
Weakness of legs or feet	_____	_____
Numbness of legs or feet	_____	_____

Previous doctors you have seen for spine problem? _____

Have you had:	Yes	No	Has it helped?	Yes	No
Bed Rest	_____	_____		_____	_____
Traction	_____	_____		_____	_____
P.T. Exercises	_____	_____		_____	_____
Chiropractic manipulation	_____	_____		_____	_____
Spine injection	_____	_____		_____	_____
Anti inflammatory meds	_____	_____		_____	_____
Pain Medicines	_____	_____		_____	_____

Have you had	Yes	No	Where?	When?
Spine x-rays	_____	_____	_____	_____
CT Scan	_____	_____	_____	_____
MRI	_____	_____	_____	_____
Bone Scan	_____	_____	_____	_____
EMG	_____	_____	_____	_____
Myclogram	_____	_____	_____	_____
Recent blood tests	_____	_____	_____	_____

OPERATIONS OR HOSPITALIZATIONS

Operation	Hospital	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mark the area on the diagram below where you have:

Ache
AA

Numbness
0000

Pins & Needles
xxxx

Stabbing
////

Burning
####

Shooting
yyyy

FRONT SIDE

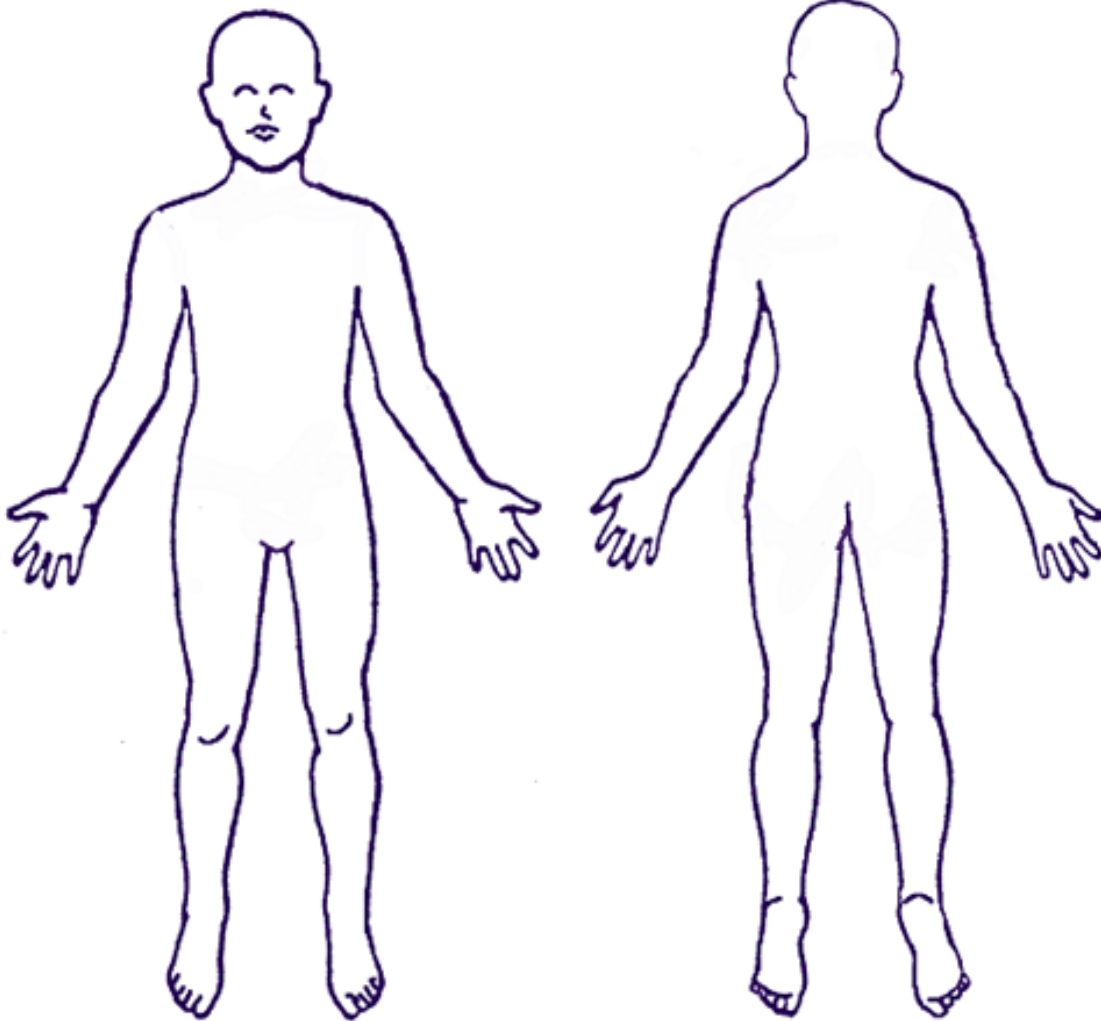
Right Side

Left Side

BACK SIDE

Left Side

Right Side



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

0 1 2 3 4 5 6 7 8 9 10

Mild

Worse

I have reviewed the above information and hereby incorporate this into the medical record.

_____ M.D. Date _____