



Institute for Low Back and Neck Care
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PATIENT INFORMATION

Name: _____ Exam Date: _____

Patient ID: _____

Have you had any physical therapy? ___yes ___no

If yes, please list where you had your therapy and approximate dates of treatment.:



VISUAL PAIN SCALE

Please fill in the appropriate circle with 0 being no pain and 10 being pain as bad as it could be.



•BACK PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be



•LEFT LEG PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be



•RIGHT LEG PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be

•NECK PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be

•LEFT ARM PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be

•RIGHT ARM PAIN SCALE

	0	1	2	3	4	5	6	7	8	9	10	
No Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain as bad as it could be