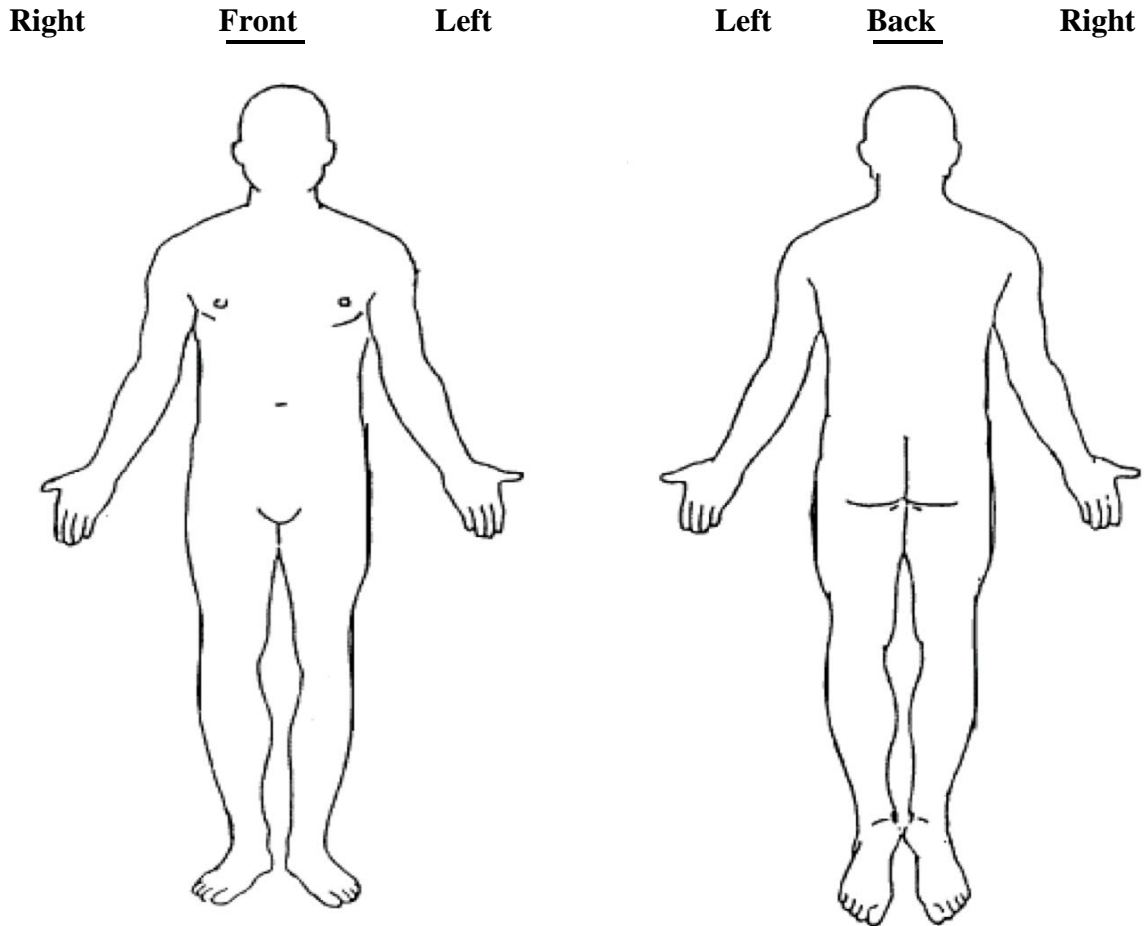


# Dr. Franklin/Spine Specialist Forms

To assist in providing the best care possible, Dr. Franklin requests that you answer each of the following questions:

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Please place X's on the diagram below where you are experiencing pain or numbness.**



**My primary pain is in my: (CIRCLE ONLY ONE PLEASE)**

Neck    Arm    Upper Back    Lower Back    Abdomen    Buttock    Thigh/Leg    Shoulder/Arm

**On a scale of 0 to 10, with zero being no pain and ten being excruciating pain, I would rate my pain **today** as:  
(CIRCLE ONLY ONE PLEASE)**

0    1    2    3    4    5    6    7    8    9    10

**On a scale of 0 to 10, I would rate my pain over the **last two weeks** as:  
(CIRCLE ONLY ONE PLEASE)**

0    1    2    3    4    5    6    7    8    9    10

Age : \_\_\_\_\_ S ex: Male  Female   
Height: \_\_\_\_\_ We ight: \_\_\_\_\_

**My chief complaint is:** \_\_\_\_\_

**This problem has been occurring for:**

\_\_\_\_\_ Days \_\_\_\_\_ W eeks \_\_\_\_\_ M onths \_\_\_\_\_ Y ears

Was there a specific incident that caused your current problem? Please explain: \_\_\_\_\_

Please describe the nature of your pain: (**Please circle** the appropriate description below)

Sharp A ching S tabbing B oring S queezing  
Dull B urning L ancinating T hrobbing Other \_\_\_\_\_

If you experience both neck and arm pain, what percentage is each? \_\_\_\_\_ % neck pain, \_\_\_\_\_ % arm pain

If you experience both back and leg pain, what percentage is each? \_\_\_\_\_ % back pain, \_\_\_\_\_ % leg pain

What makes your pain better: \_\_\_\_\_

What makes your pain worse: \_\_\_\_\_

What types of treatment have you tried? \_\_\_\_\_

Have you experienced any recent changes in you bowel habit? Yes  No

Do you experience any loss of bowel or bladder control (accidents)? Yes  No

Are you experiencing any weakness? If so where? **please circle below**

**Neck Shoulder Arm Hand/Wrist Lower Back Buttock Thigh Leg Ankle/Foot**

Are you experiencing any areas of numbness? If so where? \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Patient Name \_\_\_\_\_

## REVIEW OF SYSTEMS

Do you have any of the following: (CIRCLE all that apply)

**General:**

Fevers, chills, night sweats, nausea, vomiting, lethargy, fatigue, unexplained weight loss

**Skin/Breasts:**

Rashes, lumps under the skin, swollen lymph nodes, nipple discharge

**Cardiovascular:**

Chest pain, skipped or irregular heart beats, heart murmur, fast or slow heart beats, chest tightness or pressure, swollen extremities

**Endocrine:**

Hot or cold intolerance, frequent urination, brittle bones

**Eyes/Ears/Nose/Mouth/Throat:**

Sore throat, sores in mouth, difficulty swallowing or getting food down, swollen lymph nodes

**Genitourinary:**

Trouble with urination, dribbling, difficulty with starting a stream, frequent urinary tract infections, burning with urination, cloudy urine

**Gastrointestinal:**

Bloating, abdominal pain, pain after eating, trouble with bowel movements, blood in stool, constipation, diarrhea

**Hematological:**

Easy bleeding or bruising, bleeding with tooth brushing

**Musculoskeletal:**

Pain in the joints, muscle pains, limitation of range of motion, muscle cramping

**Neurological:**

Seizures, headaches, vision problems, problems with swallowing, in coordination, difficulty using hands, difficulty walking, frequent falls, memory loss, shuffling gait, slurred speech

**Psychiatric:**

Anxiety, stress, depression, bipolar, panic attacks, mania, trouble controlling mood, alcohol or drug dependence, sleep disturbance

**Respiratory:**

Trouble breathing, frequent coughing, production of sputum, blood in sputum, shortness of breath, difficulty sleeping on your back, shortness of breath when sleeping, snoring.

\_\_\_\_\_  
Doctor's Signature