

Patient Name _____

In order to properly assess your condition, we must understand how much your BACK/LEG (SCIATIC) PAIN has affected your ability to manage everyday activities. For each item below, please circle the answer which most closely describes your PRESENT condition. (R = Right, L = Left, B = Both)

LOCATION OF PAIN NONE

LUMBAR

Back	Buttox	Hips	Upper Leg (Thigh)	Lower Leg (Calf)	Feet
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE IS MORE PAINFUL? RIGHT LEFT EQUAL NOT APPLICABLE (N/A)

LOCATION OF NUMBNESS OR TINGLING NONE

LUMBAR

Back	Buttox	Hips	Upper Leg (Thigh)	Lower Leg (Calf)	Feet
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE HAS LESS SENSATION? RIGHT LEFT EQUAL NOT APPLICABLE (N/A)

LOCATION OF WEAKNESS NONE

LUMBAR

Back	Buttox	Hips	Upper Leg (Thigh)	Lower Leg (Calf)	Feet
R L B	R L B	R L B	R L B	R L B	R L B

WHICH SIDE IS WEAKER? RIGHT LEFT EQUAL NOT APPLICABLE (N/A)

WHEN DID YOUR BACK /LEG (SCIATIC) PAIN BEGIN? _____

WHAT CAUSED YOUR PRESENT BACK/LEG (SCIATIC) PAIN TO START? (ONSET)

Started Gradually Work Injury Motor Vehicle Accident Personal Injury No injury, Woke up with it Other

IF YOUR BACK PAIN STARTED AFTER AN INJURY, PLEASE DESCRIBE BRIEFLY.

HOW WOULD YOU DESCRIBE YOUR BACK /LEG (SCIATIC)? (CHARACTER)

- | | | | | |
|---------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> DULL | <input type="checkbox"/> SHARP | <input type="checkbox"/> THROBBING | <input type="checkbox"/> NAGGING | <input type="checkbox"/> PRESSURE |
| <input type="checkbox"/> ACHING | <input type="checkbox"/> SHOOTING | <input type="checkbox"/> BURNING | <input type="checkbox"/> STABBING | <input type="checkbox"/> OTHER |

**BACK PAIN
NEW PATIENT HISTORY**

ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF BACK PAIN? (BACK PAIN INTENSITY)

Current Level: ____/10; **Average Level:** ____/10; **Lowest Level Past 24 HRS:** ____/10; **Highest Level Past 24 HRS:** ____/10

ON A SCALE OF 0 (NONE) TO 10 (HIGHEST), WHAT IS YOUR LEVEL OF LEG (SCIATIC) PAIN? (LEG PAIN INTENSITY)

Current Level: ____/10; **Average Level:** ____/10; **Lowest Level Past 24 HRS:** ____/10; **Highest Level Past 24 HRS:** ____/10

HOW LONG HAS THE CURRENT EPISODE OF BACK/LEG (SCIATIC) PAIN BEEN PRESENT? (BACK PAIN DURATION)

<input type="checkbox"/> Just Started	<input type="checkbox"/> 1-14 Days	<input type="checkbox"/> 2-4 Weeks	<input type="checkbox"/> 4-8 Weeks	<input type="checkbox"/> 2-3 Months	<input type="checkbox"/> 3-6 Months	<input type="checkbox"/> 6-9 Months	<input type="checkbox"/> 9-12 Months	<input type="checkbox"/> Years
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WHAT PORTION OF THE AVERAGE DAY DO YOU HAVE BACK/LEG (SCIATIC) PAIN? (BACK PAIN FREQUENCY)

<input type="checkbox"/> None (0%/Day)	<input type="checkbox"/> Occasional (25%/Day)	<input type="checkbox"/> Intermittent (50%/Day)	<input type="checkbox"/> Frequent (75%/Day)	<input type="checkbox"/> Constant (100%/Day)
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WHAT TIME OF DAY IS THE BACK/LEG (SCIATIC) PAIN THE MOST SEVERE? (BACK PAIN TIMING)

<input type="checkbox"/> Mornings	<input type="checkbox"/> End of day	<input type="checkbox"/> After activity	<input type="checkbox"/> Varies	<input type="checkbox"/> Constant	<input type="checkbox"/> With Sleep
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HOW HAVE THE EPISODES OF BACK/LEG (SCIATIC) PAIN CHANGED SINCE THEY STARTED? (BACK PAIN EVOLUTION)

<input type="checkbox"/> Worsening	<input type="checkbox"/> Slightly Worse	<input type="checkbox"/> Unchanged	<input type="checkbox"/> Slightly Improved	<input type="checkbox"/> Improving
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DO YOU HAVE LIMITED MOVEMENT OF THE BACK OR STIFFNESS? (BACK ROM)

<input type="checkbox"/> None	<input type="checkbox"/> Mild Limitation	<input type="checkbox"/> Moderate Limitation	<input type="checkbox"/> Severe Limitation
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DO YOU HAVE BACK MUSCLE SPASMS? (BACK SPASMS)

<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
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WHICH OF THE FOLLOWING BEST DESCRIBES YOUR BACK/LEG (SCIATIC) PAIN? (BACK/LEG RATIO) NONE

<input type="checkbox"/> Only the Back hurts 100%Back/0%Leg	<input type="checkbox"/> Back hurts much more than Leg 90%Back/10%Leg	<input type="checkbox"/> Back hurts a little more than Leg 75%Back/25%Leg	<input type="checkbox"/> Back hurts about the same as Leg 50%Back/50%Leg	<input type="checkbox"/> Back hurts a little less than Leg 25%Back/75%Leg	<input type="checkbox"/> Back hurts much less than Leg 10%Back/90%Leg	<input type="checkbox"/> Only the Leg hurts 0%Back/100%Leg
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BACK PAIN AGGRAVATION/RELIEF

WHAT TENDS TO MAKE YOUR BACK/LEG (SCIATIC) PAIN WORSE? (PAIN AGGRAVATION) NONE

Bending	Squatting	Twisting	Lifting	Sitting	Standing	Walking
Kneeling	Crawling	Leaning	Activity	Work	Laying Down	Stress
Cough/Sneeze	Bowel Movement	Driving/Travel	Recreation	Housework	Weather Change	Sleep

OTHER- _____

WHAT TENDS TO MAKE YOUR BACK/LEG (SCIATIC) PAIN BETTER? (PAIN RELIEF) NONE

Heat	Ice	Inactivity	Certain Positions	Laying Down	Activity	Walking
Medication	Therapy	Stretching	Injections	Massage	Brace	TENS
Change Mattress	Chiropractic					

OTHER- _____

PAST EPISODES OF BACK PAIN

HOW MANY TIMES HAVE YOU BEEN TREATED FOR BACK/LEG (SCIATIC) PAIN IN THE PAST? (NUMBER OF PRIOR EPISODES)

<input type="checkbox"/> I Have Never Been Treated for Back/Leg (Sciatic) Pain in the Past	<input type="checkbox"/> A Few Times	<input type="checkbox"/> Several Times	<input type="checkbox"/> Many Times	<input type="checkbox"/> Constant
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HOW LONG AGO WAS THE LAST EPISODE OF BACK/LEG (SCIATIC) PAIN? (TIME SINCE PRIOR EPISODE)

<input type="checkbox"/> None	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months	<input type="checkbox"/> Years	<input type="checkbox"/> Constant
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HOW LONG DID THE LAST EPISODE OF BACK/LEG (SCIATIC) PAIN LAST? (DURATION OF PRIOR EPISODES)

<input type="checkbox"/> None	<input type="checkbox"/> Days	<input type="checkbox"/> Weeks	<input type="checkbox"/> Months	<input type="checkbox"/> Years	<input type="checkbox"/> Constant
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HOW HAVE THE EPISODES OF BACK/LEG (SCIATIC) PAIN CHANGED SINCE THEY STARTED? (FREQUENCY OF PRIOR EPISODES)

<input type="checkbox"/> None	<input type="checkbox"/> Much More Often	<input type="checkbox"/> Slightly More Often	<input type="checkbox"/> No Change in Frequency	<input type="checkbox"/> Slightly Less Often	<input type="checkbox"/> Much Less Often
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GAIT AND BALANCE SYMPTOMS

DO YOU HAVE ANY PROBLEMS WALKING ? (GAIT DISTURBANCE SEVERITY)

<input type="checkbox"/> No Problem Walking	<input type="checkbox"/> Mild Problem Walking	<input type="checkbox"/> Moderate Problem Walking	<input type="checkbox"/> Severe Problem Walking
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HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR WALKING? (GAIT DISTURBANCE DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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DO YOU HAVE PROBLEMS WITH YOUR BALANCE, SUCH AS FREQUENT FALLING? (BALANCE SYMPTOMS SEVERITY)

<input type="checkbox"/> No Balance Problems	<input type="checkbox"/> Mild Balance Problems	<input type="checkbox"/> Moderate Balance Problems	<input type="checkbox"/> Severe Balance Problems
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HOW LONG HAVE YOU HAD PROBLEMS WITH YOUR BALANCE OR COORDINATION? (BALANCE DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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DO YOU USE ANY DEVICES TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES)

<input type="checkbox"/> None	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Scooter
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HOW LONG HAVE YOU USED THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES DURATION)

<input type="checkbox"/> N/A	<input type="checkbox"/> A Few Days	<input type="checkbox"/> A Few Weeks	<input type="checkbox"/> A Few Months	<input type="checkbox"/> 6 Months or More	<input type="checkbox"/> One year or More
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WHY DO YOU USE THE DEVICE TO HELP YOU TO WALK? (GAIT ASSISTIVE DEVICES NECESSITY)

<input type="checkbox"/> N/A	<input type="checkbox"/> To Relieve Stress on the Back	<input type="checkbox"/> For Weak Leg(s)	<input type="checkbox"/> For Balance Problems	<input type="checkbox"/> Other
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WORK STATUS

ARE YOU WORKING AT THIS TIME? (WORK STATUS)

<input type="checkbox"/> Yes -Full Duty	<input type="checkbox"/> Yes – with Restrictions	<input type="checkbox"/> Not Working - due to illness	<input type="checkbox"/> Not Working– by choice	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired	<input type="checkbox"/> Disabled
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OCCUPATION - _____

ASSOCIATED SYMPTOMS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (SYSTEMIC SYMPTOMS)

frequent fevers or chills	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
generalized weakness or fatigue	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
unplanned weight loss greater than 10 lbs	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
recent trauma, fall or accident	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
night pain that wakes you up from sleep	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
night pain that stops you from falling asleep	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CAUDA EQUINA SYMPTOMS)

Do you have loss of bladder control?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
Do you have loss of bowel control?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
Do you have numbness in the genital region?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (NEUROGENIC CLAUDICATION SYMPTOMS)

Do you have numbness or tingling in the legs <u>CAUSED</u> by walking and <u>RELIEVED</u> by bending over forward?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (SHOPPING CART SIGN SYMPTOMS)

Are you able to walk farther while leaning over and holding on to a shopping cart?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (PERIPHERAL NEUROPATHY SYMPTOMS)

Have you been diagnosed with peripheral neuropathy?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
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DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (HIP SYMPTOMS)

Do you have pain in the groin region?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
Do you have limited movement of the hips?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (VASCULAR SYMPTOMS)

Have you been diagnosed with poor circulation in the legs?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
Have you been diagnosed with an aneurysm?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (OTHER SYMPTOMS)

treatment for anxiety	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
treatment for depression	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
treatment for fibromyalgia	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
treatment for chronic pain	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
treatment for alcohol abuse	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)
treatment for drug abuse	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEW (<1MONTH)	<input type="checkbox"/> OLD (>1MONTH)

Please Read: This questionnaire is designed to give the doctor information as to how your back/leg (sciatic) pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section may relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

Section 2 – Personal Care

- I would not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (Skip if you have not attempted lifting since the onset of your low back pain).

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if conveniently positioned (on a table).
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift light weights at the most.

Section 4 – Walking

- I have no pain on walking.
- I have some pain on walking, but I can still walk my required normal distances.
- Pain prevents me from walking long distances.
- Pain prevents me from walking intermediate distances.
- Pain prevents me from walking even short distances.
- Pain prevents me from walking at all.

Section 5 – Sitting

- Sitting does not cause me any pain.
- I can sit as long as I need provided I have my choice of sitting surfaces.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I can't stand for more than 1 hr without increasing pain.
- I can't stand for more than ½ hr without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

Section 7 – Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my night's sleep is only ¾ of normal.
- Because of pain, my night's sleep is only ½ of normal.
- Because of pain, my night's sleep is only ¼ of normal.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities (sports, dancing, etc.).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

Section 9 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- I get some pain while traveling, but it does not make me seek alternative forms of travel.
- I get extra pain while traveling which requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done while lying down.

Section 10 – Employment/Homemaking

- My normal job/homemaking activities do not cause pain.
- My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (lifting, vacuuming, etc.).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from even light duties.
- Pain prevents me from performing any job or homemaking chore.

RAW Score X 2 = Oswestry Low Back Pain Disability Score
0-20 – mild; 20-40 – moderate; 40-60 – severe; >60 – very severe.

PAST LUMBAR SPINE TREATMENT

Diagnostic Tests

HAVE YOU HAD ANY DIAGNOSTIC TESTING DONE ON YOUR LOWER BACK?

<input type="checkbox"/> Back X-ray	<input type="checkbox"/> Back MRI	<input type="checkbox"/> CT-Myelogram	<input type="checkbox"/> EMG/NCV Nerve Test	<input type="checkbox"/> Discogram	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> Bone Density
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Past Treatments

IN THE PAST ONE YEAR HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS FOR YOUR BACK/LEG (SCIATIC) CONDITION?

<input type="checkbox"/> Medications <input type="checkbox"/> Helped	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Helped	<input type="checkbox"/> Massage Therapy <input type="checkbox"/> Helped	<input type="checkbox"/> Back Brace <input type="checkbox"/> Helped
<input type="checkbox"/> Chiropractic <input type="checkbox"/> Helped	<input type="checkbox"/> TENS Unit <input type="checkbox"/> Helped	<input type="checkbox"/> Epidural Injections (ESI's) <input type="checkbox"/> Helped	<input type="checkbox"/> Other

Medications

PLEASE LIST ALL MEDICATIONS YOU HAVE TAKEN FOR YOUR BACK/LEG (SCIATIC) CONDITION IN THE PAST SIX MONTHS.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING FOR YOUR BACK/LEG (SCIATIC) CONDITION.

Physical Therapy

Have you been treated with PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition? YES NO

When did you go to PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition? _____

How long did you go to PHYSICAL THERAPY for your BACK/LEG (SCIATIC) condition? _____

Did the PHYSICAL THERAPY help your BACK/LEG (SCIATIC) condition? _____

Epidural Injections

Have you been treated with EPIDURAL STEROID INJECTIONS for your BACK/LEG (SCIATIC) condition? YES NO

How many EPIDURAL STEROID INJECTIONS have you had for your BACK/LEG (SCIATIC) condition? _____

When was the last EPIDURAL STEROID INJECTIONS for your BACK/LEG (SCIATIC) condition? _____

How long do the EPIDURAL STEROID INJECTIONS usually last for your BACK/LEG (SCIATIC) condition? _____

Surgery

PLEASE LIST ANY PREVIOUS LOWER BACK SURGERY. PLEASE INCLUDE DATES, HOSPITAL, CITY AND PHYSICIAN IF KNOWN.

DID THE SURGERY HELP YOUR BACK/LEG (SCIATIC) CONDITION?

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DID YOU HAVE ANY COMPLICATIONS WITH YOUR BACK SURGERY?

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