Body•Mind
Balanced Wellbeing
RECONNECT NATURALLY TO YOUR HEALTH.

CERVICAL EVALUATION: Upper Spine

(Circle best description)

Name_____Date_____ DOB_____

Are you aware of when/how this happened? YES/NO _____

Have you ever had anything like this happen before? YES/NO _____

Did you feel any tearing/popping? YES/NO _____

Can you point to the exact location(s) YES/NO If so, place a circle on the area(s) associated below

Describe the sensation: DULL SHARP BURNING ACHING THROBBING SHOOTING

Describe the intensity: MILD MODERATE SEVERE Describe the frequency: CONSTANT ON/OFF

Has it been getting better or worse? BETTER WORSE _____

What relieves it?_____What makes it worse? _____

Does this interfere with your sleeping? YES/NO How do you feel in the morning? STIFF/FINE

Does the pain radiate to the base of the skull or down the arms? YES/NO

Does it give you headaches? YES/NO if so, where? _____(Place an "X" on diagram below)

Is there numbness or tingling in arms and hands? YES/NO Do any drugs relieve the pain? YES/NO

Do you or have you ever cracked your own neck? YES/NO

Have you seen any other healthcare professional for this condition? YES/NO if so, who?_____

What were the results of this care?_____Diagnosis?_____

Do you have complaints in any other part of your body that we haven't discussed? YES/NO _____

_____

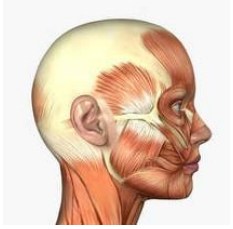
Do you exercise? NONE LIGHT MEDIUM HEAVY

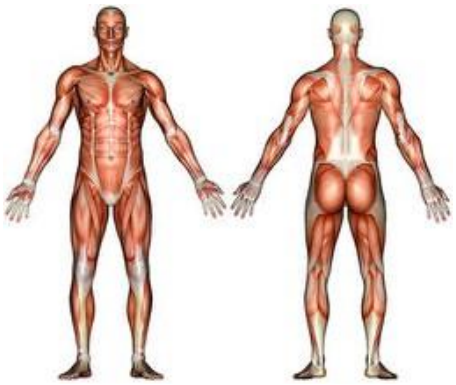
Do you smoke? YES/NO Have you smoked? YES/NO

Do you get lightheaded, dizzy or have blurred vision? YES/NO

Women: Do you take birth control medications? YES/NO

Rate your overall health? Bad FAIR GOOD EXCELLENT





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LUMBAR EVALUATION: Lower Spine

(Circle best description)

Name_____Date_____ DOB_____

Are you aware of when/how this happened? YES/NO _____

Have you ever had anything like this happen before? YES/NO _____

Did you feel any tearing/popping? YES/NO _____

Can you point to the exact location(s) YES/NO If so, place a circle on the area(s) associated below

Describe the sensation: DULL SHARP BURNING ACHING THROBBING SHOOTING

Describe the intensity: MILD MODERATE SEVERE

Describe the frequency: CONSTANT ON/OFF

Has it been getting better or worse? BETTER WORSE _____

What relieves it?_____What makes it worse? _____

Does this interfere with your sleeping? YES/NO

How do you feel in the morning? STIFF/FINE

What position do you sleep? BACK STOMACH SIDE

What posture aggravates the pain? STANDING SITTING LEANING FORWARD

Does the pain move up or down the spine? YES/NO

Do any drugs relieve the pain? YES/NO

Is there pain or numbness in your legs or feet? YES/NO where?_____

If there is pain/numbness, is it: CONSTANT ON/OFF How long does it last?_____

Does the pain radiate into your abdomen? YES/NO

Is there impairment of bowel or urinary function? YES/NO

Do you exercise? NONE LIGHT MEDIUM HEAVY

Do you smoke? YES/NO Have you smoked? YES/NO

Do you get lightheaded, dizzy or have blurred vision? YES/NO

Women: Do you take birth control medications? YES/NO

Rate your overall health? Bad FAIR GOOD EXCELLENT