



Portland NEUROSURGERY

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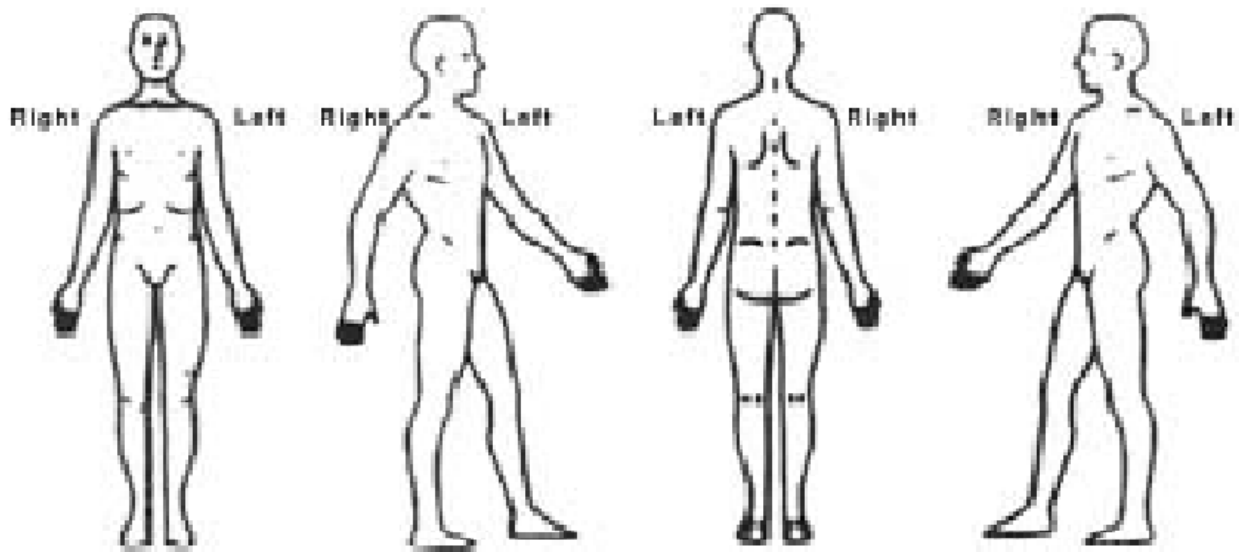
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Primary Problem Form – Lumbar Spine

Briefly describe your symptoms

If you have pain, or if pain was previously part of the problem, please indicate the location



Do you have **numbness** and/or **tingling**? Yes No

Do you have **weakness** or **loss of strength**? Yes No

How long have you had these symptoms? _____

Did the symptoms start as a result of an accident or incident? Yes No

If so, please describe _____

What makes you pain or other symptoms worse? (Please check all that apply)

- | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Activity |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Time of day | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Work | |

Please Complete Both Sides!

What other treatments have you tried for this problem? (Please check all that apply)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Ice/Heat | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Anti-inflammatory medications
(e.g. aspirin, advil, ibuprofen, aleve, naproxen) | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Narcotic pain medications | <input type="checkbox"/> Injections |
| <input type="checkbox"/> Muscle relaxants | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Physical Therapy | |

Have you missed work because of these symptoms? Yes No

Please refer to the pain scale below

What is the **current** level of your pain? _____

What has been the **maximum** level of your pain? _____

Subjective Pain Scale		
	0	No pain. Feeling perfectly normal.
Minor Able to adapt to pain	1 Very Mild	Very light barely noticeable pain
	2 Discomforting	Minor pain, like lightly pinching the fold of skin
	3 Tolerable	Very noticeable pain, like a doctor giving you an injection
Moderate Interferes with many activities.	4 Distressing	Strong, deep pain, like an average toothache
	5 Very Distressing	Strong, deep, piercing pain, such as a sprained ankle
	6 Intense	Strong, deep, piercing pain like several bee stings
Severe Patient is disabled and unable to function independently.	7 Very Intense	Comparable to an average migraine headache
	8 Utterly Horrible	Comparable to childbirth or a real bad migraine headache
	9 Excruciating Unbearable	Pain so intense you cannot tolerate it and demand pain killers
	10 Unimaginable Unspeakable	Pain so intense you will go unconscious shortly.

Please Complete Both Sides!

Please Complete Both Sides!