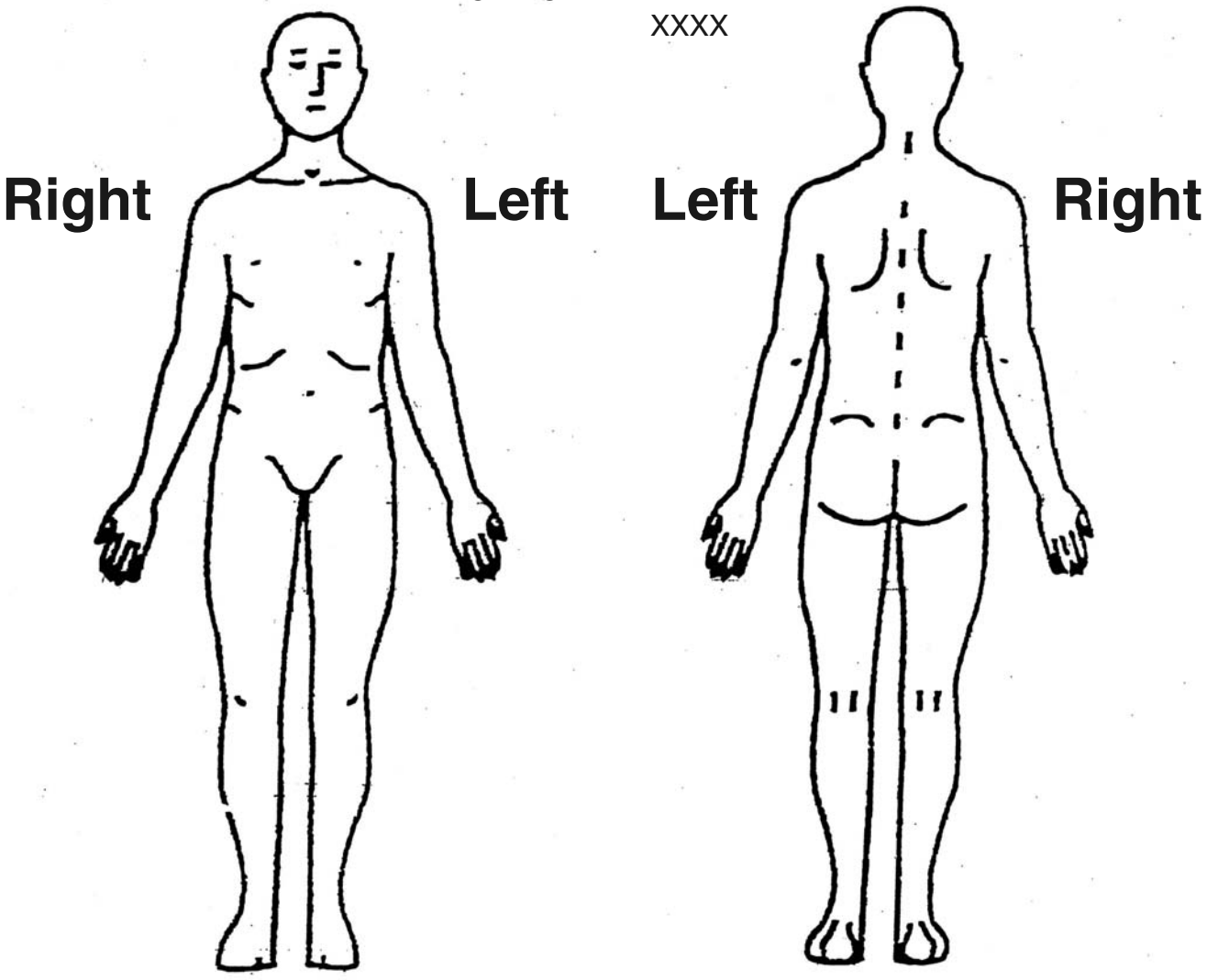
BACK EVALUATION
(PAGE 1 TO BE FILLED OUT BY PATIENT)

Name_____ Age_____
Address _____
_____
Occupation_____ Are you working now? _____
If not working, when did you last work? _____
Referring Physician_____
Present Height_____ Weight _____

Mark the area you feel the described sensations. Use the symbols below. Include all affected areas.

NUMBNESS - ——
————

BURNING - 0000
0000

STABBING - ////////
////////

ACHING - XXXX
XXXX