Back Institute
Administrative Offices
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Los Angeles, CA 90035
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www.backinstitute.com

More than 1 week Post Surgery Form

NAME: _____ AGE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____

City: _____ State: _____

TODAY'S DATE: ____/____/_____ Date of Surgery: ____/____/____

Do you have occasional back or leg pain (neck or arm pain, if it was a neck problem) severe enough to interfere with normal work or leisure activities? YES NO

Are you handicapped by severe pain? YES NO

How are your symptoms different in comparison to prior to your procedure?

What medication are you taking and what is the total daily dosage?

Are you having or have you had any physical therapy(at home or at a therapy center?)Please describe:

Have you done therapy per our protocol, or extended protocol? YES NO
If No, please describe why not:

Is there any stress to your spine during therapy? YES NO
If YES, please describe:

Has there been any problem with physical therapy? YES NO
If YES, please describe:

Please provide the name and phone number of your PT facility:

When did you return to work?

Are you working at the same job as prior to the start of your back problem? If a different job, please describe:

Working full time?

No limitation or if there is a limitation at work, please describe:

What activities are you doing?