

**PLEASE TAKE TIME TO FILL OUT THE APPROPRIATE SPACES.**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Present Job \_\_\_\_\_

When did your back or neck pain originally start? \_\_\_\_\_

When did your arm or leg pain originally start? \_\_\_\_\_

When did your current episode begin? \_\_\_\_\_

Did your pain start gradually \_\_\_\_\_ Suddenly \_\_\_\_\_ Injury \_\_\_\_\_

Do you have numbness or tingling in an arm or leg? Please describe  
\_\_\_\_\_

Are there any recent changes in bowel or bladder habits? Please describe.  
\_\_\_\_\_

My pain is: check the appropriate box.                      BETTER                      WORSE                      NO DIFFERENT

With cough or sneeze                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

Lying flat on stomach                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

On side with knees bent                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

When bending                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

When lifting                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

Standing                      \_\_\_\_\_                      \_\_\_\_\_                      \_\_\_\_\_

How long can you sit? \_\_\_\_\_

How long can you walk? \_\_\_\_\_

Have you had neck or back surgery? \_\_\_\_\_

Number of times \_\_\_\_ .      Please give dates and types \_\_\_\_\_

What treatments have made your pain better? \_\_\_\_\_

What treatments have made your pain worse? \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Do you have an attorney helping you? \_\_\_\_\_

Did you have to change jobs \_\_\_\_\_ To what? \_\_\_\_\_

Are you under any pressure at home? \_\_\_\_\_ At work? \_\_\_\_\_

Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

What can you not do because of your pain that you want to do? \_\_\_\_\_

What was the date of your last physical exam and the name of the M.D.

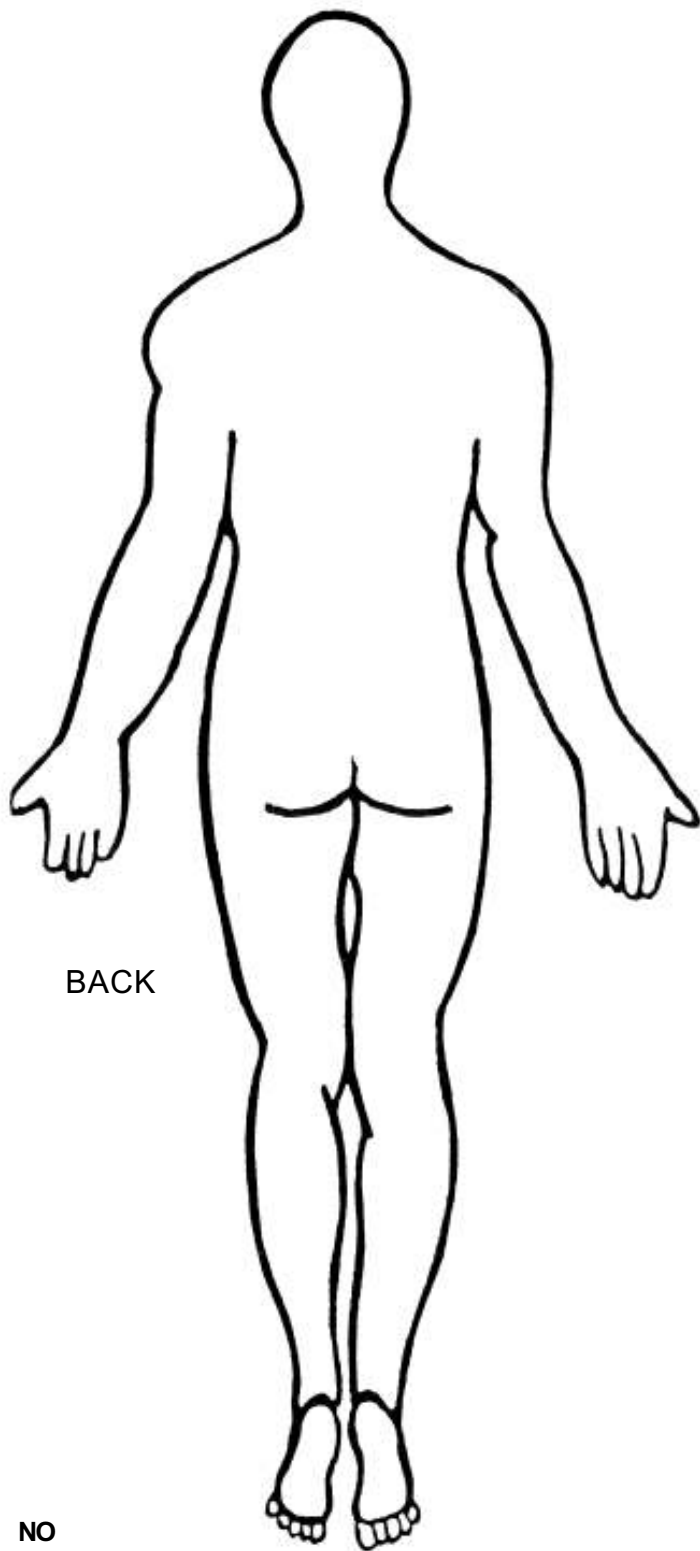
Who did it? \_\_\_\_\_

Pelvic done? \_\_\_\_\_ Rectal done? \_\_\_\_\_

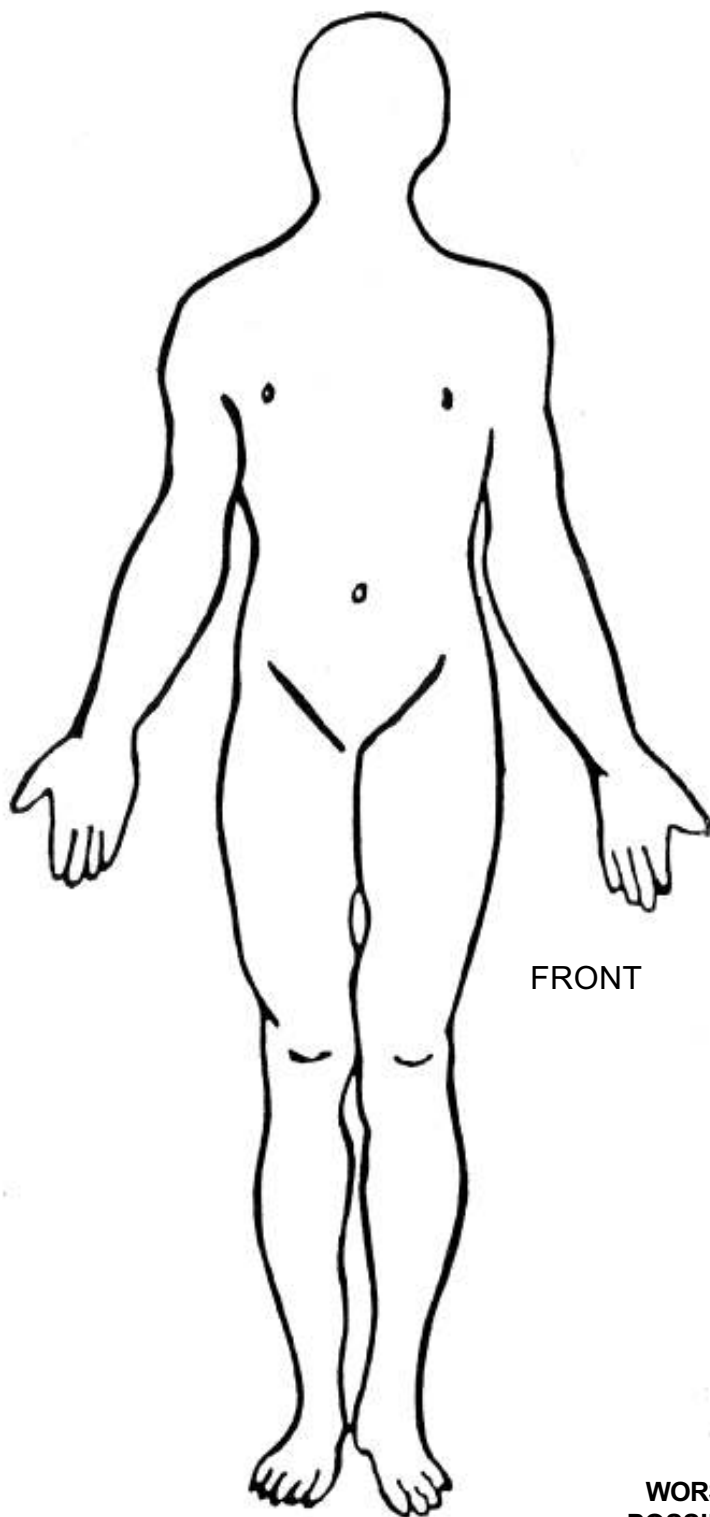
Name \_\_\_\_\_ Date \_\_\_\_\_

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

NUMBNESS	....	PINS & NEEDLES	0000	BURNING	XXXX	PAIN	////
	....		0000		XXXX		////
	....		0000		XXXX		////



BACK



FRONT

