

Have you had any auto or other accidents? No Yes

Describe: _____

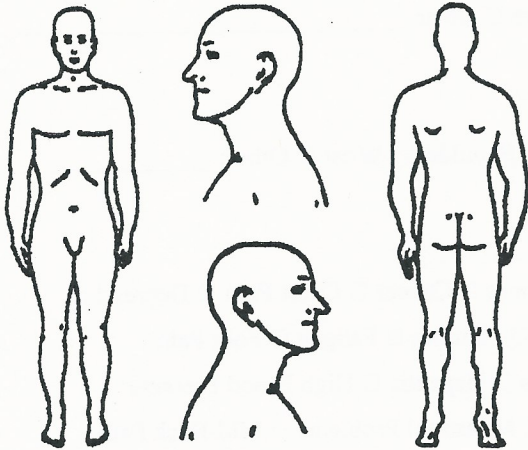
Date of last physical examination: _____ Do you smoke? No Yes

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

... 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____