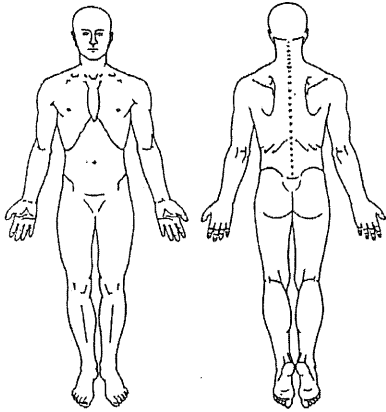


For Back/Neck Pain Only

ON A SCALE OF 0-10, WHERE ZERO IS NO PAIN AND 10 IS THE WORSE IMAGINABLE PAIN:

- CIRCLE THE NUMBER THAT REPRESENTS YOUR CURRENT PAIN LEVEL. 0 1 2 3 4 5 6 7 8 9 10
 CIRCLE THE NUMBER THAT REPRESENTS THE LEAST PAIN IN THE PAST 30 DAYS. 0 1 2 3 4 5 6 7 8 9 10
 CIRCLE THE NUMBER THAT REPRESENTS THE MOST PAIN IN THE PAST 30 DAYS. 0 1 2 3 4 5 6 7 8 9 10



The body diagram to the left is used to indicate where and what type of pain you are experiencing.

Mark as follows:
 000 = pain
 IIIII = numbness

Have you had any of the following for this injury:
 ___CT ___MRI ___EMG/NCV ___Bone Scan ___X-Rays
 ___Discogram ___Physical Therapy ___Chiropractic

IN EACH SECTION, CHECK ALL THAT APPLY TO YOUR CURRENT PROBLEM:

<input type="checkbox"/> NECK PAIN		<input type="checkbox"/> BACK PAIN	
<input type="checkbox"/> LEFT SIDE	<input type="checkbox"/> RIGHT SIDE	<input type="checkbox"/> CONSTANT PAIN	<input type="checkbox"/> PAIN COMES AND GOES
<input type="checkbox"/> LEFT LEG PAIN/NUMBNESS	<input type="checkbox"/> RIGHT LEG PAIN/NUMBNESS	<input type="checkbox"/> MORNING PAIN	<input type="checkbox"/> EVENING PAIN
<input type="checkbox"/> LEFT ARM PAIN/NUMBNESS	<input type="checkbox"/> RIGHT ARM PAIN/NUMBNESS	<input type="checkbox"/> SHOOTING PAIN	<input type="checkbox"/> BURNING PAIN
<input type="checkbox"/> BOTH LEGS PAIN/NUMBNESS	<input type="checkbox"/> PAIN WAKES ME UP AT NIGHT	<input type="checkbox"/> MEDICATION HELPS	<input type="checkbox"/> NOTHING HELPS REDUCE PAIN
<input type="checkbox"/> NO BOWEL/BLADDER CONTROL	<input type="checkbox"/> WEAKNESS IN RT/LT LEG	<input type="checkbox"/> WEAKNESS IN RT/LT ARM	<input type="checkbox"/> WEAKNESS IN EITHER HAND
PAIN INCREASES WITH:			
<input type="checkbox"/> SITTING	<input type="checkbox"/> STANDING	<input type="checkbox"/> BENDING	<input type="checkbox"/> SQUATTING
<input type="checkbox"/> LIFTING	<input type="checkbox"/> TURNING	<input type="checkbox"/> JUMPING	<input type="checkbox"/> REACHING
<input type="checkbox"/> WALKING	<input type="checkbox"/> COUGHING	<input type="checkbox"/> LYING DOWN	<input type="checkbox"/> DRIVING
PAIN DECREASES WITH:			
<input type="checkbox"/> SITTING	<input type="checkbox"/> STANDING	<input type="checkbox"/> BENDING	<input type="checkbox"/> SQUATTING
<input type="checkbox"/> LIFTING	<input type="checkbox"/> TURNING	<input type="checkbox"/> JUMPING	<input type="checkbox"/> REACHING
<input type="checkbox"/> WALKING	<input type="checkbox"/> COUGHING	<input type="checkbox"/> LYING DOWN	<input type="checkbox"/> DRIVING
Describe your pain in your own words: _____			

Please list any medications that you are currently taking (include the amount, frequency, and how long): _____

PAST MEDICAL HISTORY

Medical History: Please list all illnesses (Example high blood pressure, diabetes, cancer, heart, lung, liver, or kidney problems)

Prior Surgeries (with dates): _____

Hospitalizations (dates): _____
