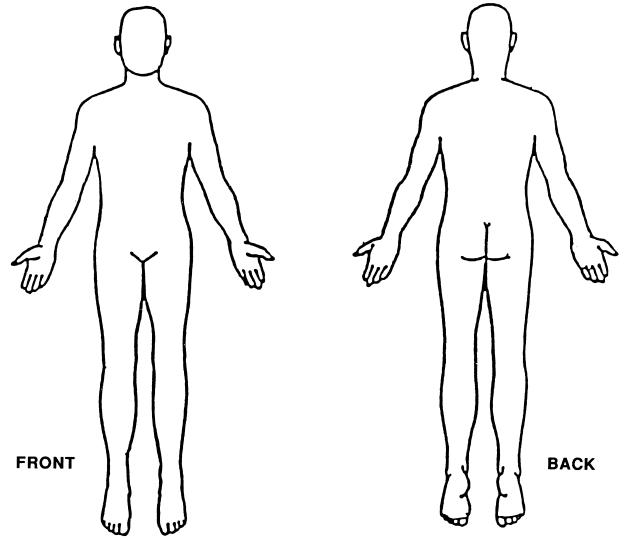
Name	······		Date					
Occupation			Age					
1 - For what condition / symptoms are you being seen at this time?								
2 - When did it start (give approxima								
3 - How did it start? (If accident or in								
4 - Please give a step by step history present. When possible, give app		•						
5 - Do you have back pain?								
6 - Do you have leg pain? If so, right, left or both? If both, which side is worse?	<del>-</del>							
7 - Do you have neck pain?								
8 - Do you have arm or shoulder pair If so, right, left or both? Which side is worse?	1?							
9 - Please describe your pain, includi	ing activities	s which help o	r make it worse	<b></b>				
Coughing Bending Lifting Sitting / Driving Standing	Yes ( ) ( ) ( ) ( )	No ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	) ) )					
10 - Do you have numbness or tinglin	ng?	W	/here?					
11 - Do you have weakness?		Where?						
12 - Do you have any bladder control								

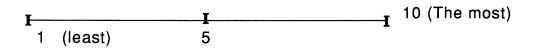
13	- Do you have any bowel control difficulties?							
14	- Employer							
15 -	- Have you ever been in a hospital for back, leg, neck, or arm pain?							
16 -	- Have you ever had a myelogram (X-ray of the spine with dye injection)? Dates Who ordered it?							
18 -	- Have you ever had an MRI? Dates Who ordered it?							
19 -	- Have you ever had an EMG? Dates							
20 -	- Do you exercise on a regular basis?							
21 -	- What is your weight?							
22 - What other doctors or chiropractors have you seen for this condition?								
	WhenWhere?							
23 -	- Have you ever had surgery on your back or neck?  Dates and type of surgery done?							
24 -	- What treatments have you had?  Where	Vhen						
	Chiropractic:	<u> </u>						
25 -	Please list medications you have taken for pain or spasm during the past year, and include dose and number taken per day?							

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
A A A A	$x \; x \; x \; x$	0000	/ / / /	= = = =
A A A A	X X X X	0000	/ / / /	= = = =
	_		_	



How bad is your pain now? (mark with an X)



How bad is your pain at its worst?

