Date:_____ Name: _____ _____ _____ Nickname:_____ D.O.B. _____
Last First M.I.

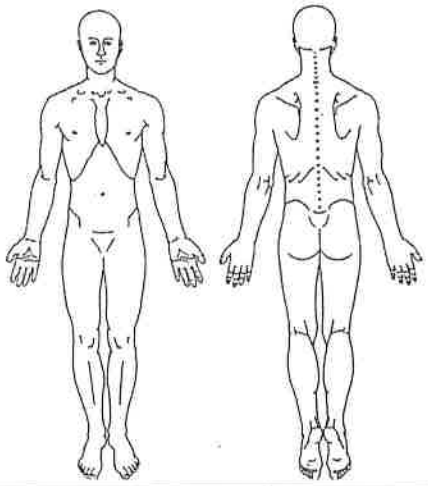
Sex: M / F Height: _____ Weight: _____ Age: _____ Occupation: _____

Date of Injury/onset:_____ Date of Surgery:_____ Are you currently working? **Y / N**

Has your physician placed you on any work restrictions? **Y / N** If yes, please explain:_____

Symptom Location

Please mark the diagram in areas affected using:
X= Pain ~ = Tingling/Numbness



Symptom Description (Check all those applicable)

[ ] Constant [ ] Intermittent [ ] Burning [ ] Sharp [ ] Dull/Achy
[ ] Radiating (location:_____) [ ] Numbness

Symptom Intensity *0= No Pain, 5=Moderate Pain, 10=Extreme Pain*

Worst	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Current	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Best	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Symptom History

Briefly describe how and when your symptoms began: _____

_____

_____

_____

Other Symptoms

*Increased Pain at Night? **Y / N** *Pain with Coughing/Sneezing? **Y / N**
*Dizziness/Nausea? **Y / N** *Unexplained weight loss or gain? **Y / N**
*Any episodes of losing control of bowel or bladder function since injury? **Y / N**

Have you had previous injury to this or related area? Y / N (if yes, explain:_____)

Diagnostic Imaging

[ ] X-Ray [ ] MRI [ ] CT

What medical office were they done in?_____

_____

Findings? _____

General/Past Medical History (Check all that apply)

[ ] Cancer (location:_____)
[ ] High/Low Blood Pressure
[ ] Peripheral Vascular Disease
[ ] Cardiac Condition (explain_____)
[ ] Allergies
[ ] Tumors (location_____)
[ ] Stroke (when_____)
[ ] Diabetes
[ ] Seizures
[ ] Metal Implants
[ ] Current/Recent Pregnancy
[ ] Headaches
[ ] Pacemaker

Surgeries (date/procedure)

_____

Medications (please list dosage & frequency. Continue on back if needed)_____

_____

List 3 Activities that you are unable to perform or have the most difficulty performing because of your condition:

Score the difficulty of each activity: 0=Able to perform at same level as before the injury, 10=Unable to perform activity

_____ Score: 0 1 2 3 4 5 6 7 8 9 10

_____ Score: 0 1 2 3 4 5 6 7 8 9 10

_____ Score: 0 1 2 3 4 5 6 7 8 9 10