PATIENT MEDICAL HISTORY

PATIENT NAME (Please Print): _____

When did your symptoms begin? :_____
How did your symptoms begin? :_____
Have you had similar symptoms in the past? If yes, please describe : _____
_____
Have you been examined by a doctor for your symptoms? If yes, whom and when? :_____
_____
Have you had an MRI, X-Ray, Cat Scan or any other diagnostic procedure for your symptoms? If yes, please list :_____
Have you had any surgeries related to your symptoms? If yes, please list :_____
_____

How often do you experience your symptoms?

- ☐ Constantly (75-100% of the day)
- ☐ Frequently (50-75% of the day)
- ☐ Occasionally (25-50% of the day)
- ☐ Intermittently (0-25% of the day)

How much has your pain interfered with daily work and housework activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

Which word describes the nature of your pain?

- ☐ Sharp
- ☐ Dull Ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How much as your pain interfered with your social or recreational activities?

- ☐ Not at all
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

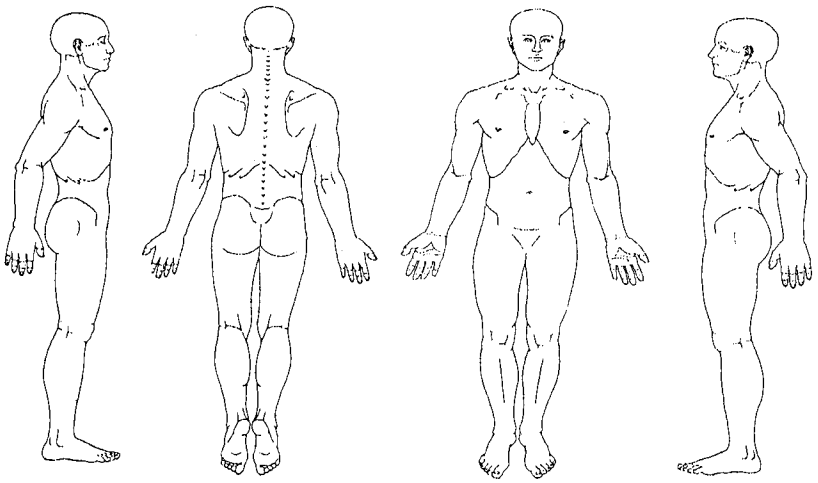
How are your symptoms changing?

- ☐ Getting better
- ☐ Getting worse
- ☐ Not Changing

In general, describe your overall health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

On the diagram below, please circle the area of the body where you are having your symptoms:



On a scale of 0-10 (10 being the most severe), how would you rate your pain level:

With Activity: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
At Rest: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

I attest that the information listed above is accurate and current to the best of my knowledge:

PATIENT SIGNATURE: _____ **DATE:** _____