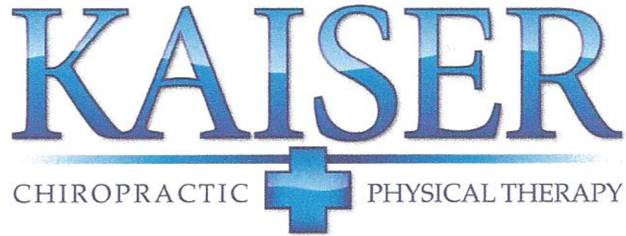

Additional complaint: ____

Onset Date: _______ Frequency (circle): constant frequent occasional intermittent

Intensity (minimal "0" – severe "10") 0 1 2 3 4 5 6 7 8 9 10

Type (circle) dull ache sharp shooting stiffness numb/tingling weakness burn

Aggravated by: ________________________ Relieved by: ________________________

Past History of this Condition?: _____ Treated?: _____ Type of treatment: __________

Tests performed (circle): X-ray MRI CTScan NCV/EMG Other: ____________

Additional complaint: ____

Onset Date: _______ Frequency (circle): constant frequent occasional intermittent

Intensity (minimal "0" – severe "10") 0 1 2 3 4 5 6 7 8 9 10

Type (circle) dull ache sharp shooting stiffness numb/tingling weakness burn

Aggravated by: ________________________ Relieved by: ________________________

Past History of this Condition?: _____ Treated?: _____ Type of treatment: __________

Tests performed (circle): X-ray MRI CTScan NCV/EMG Other: ____________

IMPORTANT: (PLEASE STOP AND THINK ABOUT THIS QUESTION)

Is there anything else you would like to tell the doctor about your condition or general health? (Example: Do you have a pacemaker? Have you had any surgeries? Are you taking any medications? Do you have cancer? Do you have heart disease? Do you have diabetes?)

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____

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(Please initial and date the bottom right hand corner of each page)