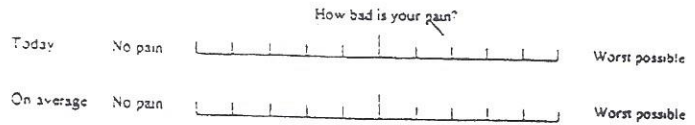
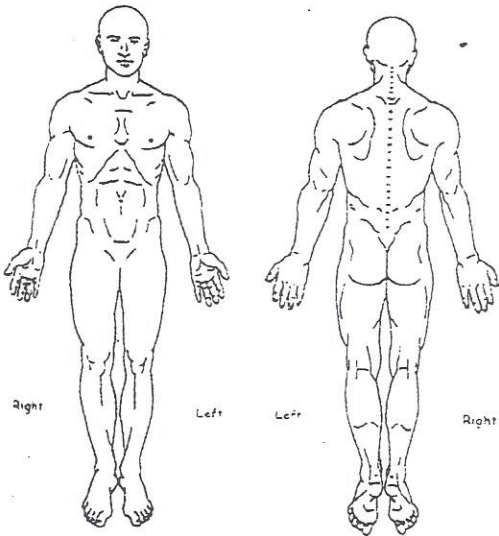


1. Reason for Consultation? _____
2. Are you experiencing any other aches or pains, numbness or weakness? Yes No _____
3. Are you presently under the care of physician or other care provider for any medical condition? _____
4. Please list any condition or chronic illness that you may have? NONE _____
5. Please fill in the pain diagram and pain scales. Use the appropriate symbols and include all affected areas.

Pain: xxxxxx Ache: +++++ Burning Sensation: IIIII Numbness or Pins & Needles: ooooo



6. Are you becoming better, worse, or remaining the same: _____
7. Aggravates your pain? _____
8. What eases your pain? _____
9. What treatments have you received? _____
10. Any diagnostic Studies? _____
11. Physicians or other health care provides whom you have consulted. _____
12. Have you ever been hospitalized? YES NO (if yes please list and give approximate date or age.)
Age: _____ Reason: _____
13. Have you ever undergone surgery? YES NO (please list and give approximate date or age.)
Age: _____ Reason: _____