REASON FOR YOUR APPOINTMENT TODAY:

_____

_____

	YES	NO	COMMENTS
Is this a result of an injury at work?			
Is this a result of an injury in a motor vehicle accident?			
Have you had an MRI?			
Have you had a CT scan?			
Have you had a myelogram?			

Please check any prior treatments that apply:	X	COMMENTS
-physical therapy		
-chiropractic therapy		
-steroid injections		
-other (please describe)		

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU ARE BEING EVALUATED OR TREATED FOR BACK PAIN. ALL OTHER PATIENTS PLEASE DISREGARD

PAIN SYMPTOMS

Using an "X", please mark on the line below how much pain you have had from **your back** in the **last seven days.**

0 1 2 3 4 5 6 7 8 9 10

no pain at all — maximum pain possible

In the **past week** how often have **you suffered**: (please mark one box per line)

	None of The time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
Leg pain?	☐	☐	☐	☐	☐	☐
Numbness or tingling in leg and/or foot?	☐	☐	☐	☐	☐	☐
Weakness in leg and/or foot?	☐	☐	☐	☐	☐	☐

In the **past week**, how bothersome have these symptoms **been**? (please mark one box per line)

	Not at all Bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Leg pain?	☐	☐	☐	☐	☐	☐
Numbness or tingling in leg and/or foot?	☐	☐	☐	☐	☐	☐
Weakness in leg and/or foot?	☐	☐	☐	☐	☐	☐

Patients Initials: _____ Date: _____ / _____ / _____

Month Day Year

MD signature _____