

MEDICAL HISTORY

NAME _____ Prefer to be called _____ DATE _____ AGE _____

1. Have you ever had any of the following: YES NO (Circle below all conditions that apply)
- | | | | | |
|---------------|--------------|---------------------|----------|---------------------|
| Heart Disease | Angina | Cancer | Diabetes | High Blood Pressure |
| Blood Clots | Emphysema | Pacemaker | Asthma | Stroke |
| Epilepsy | Osteoporosis | Other (list): _____ | | |

Are you or might you be pregnant at this time? Yes No

Surgery (list): _____

2. Medications taking: _____

3. How long have you had the condition for which you were referred to our office? _____

4. What treatments have you had for this condition? _____

5. Is there anything that makes this condition better? _____

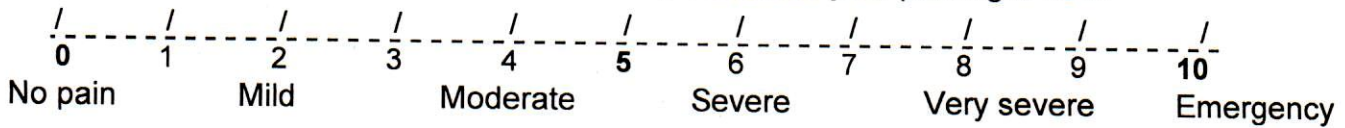
6. Is there anything that makes this condition worse? _____

7. Affects on sleep: _____

8. What diagnostic tests have you had for this condition? Circle below the tests you have had:

X-RAYS CATSCAN MRI EMG

9. Please circle the one choice which most closely describes your pain right now:



10. Using the above scale, rate your pain:
Worst pain past month (0 to 10) _____
Least pain past month (0 to 10) _____

11. Please indicate on the drawing at right where your pain is that we are treating today (if you have any):

