Name__________________________ Birth date: ___/____/____

Please answer the following as best you can. Please print legibly.

Describe your problem and how long you have had it:
____
____

Have you been injured: (circle) Yes No
If yes, when?____
Please describe your injury:____
____
____

Is this work or motor vehicle related? (circle) Yes No

Have you had surgery for this problem? (circle) Yes No
If yes, when? ____

Please describe your surgery: ____
____
____

Have you had any other tests for this problem? (circle) Yes No
If yes, please tell us what, when, where, and the results.
Myelogram____
CT Scan ____
MRI Scan____

Please circle your symptoms:

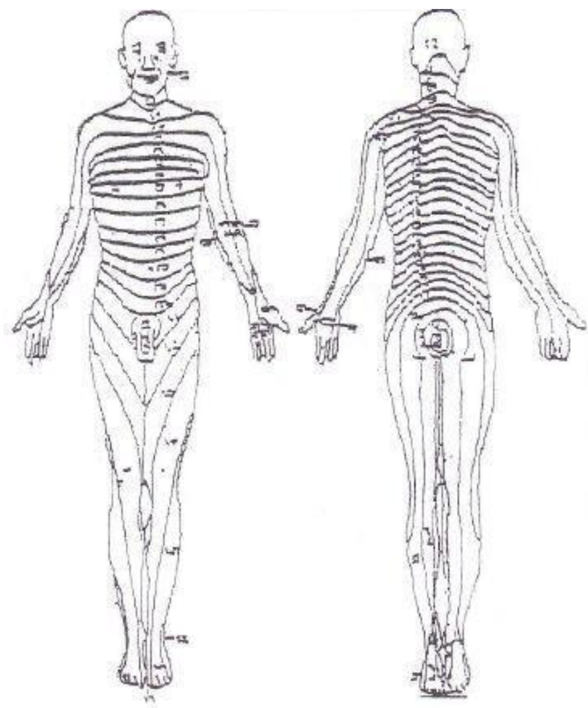
Neck pain: Right Left

Arm pain: Right Left
Arm numb: Right Left
Arm weak: Right Left

Leg pain: Right Left
Leg numb: Right Left
Leg weak: Right Left

Bowel Dysfunction:
Yes No
Bladder Dysfunction:
Yes No

Please shade where your pain is in this drawing.



Signature: ______________________________________ Date:______________