

Do you have?	Where?
<input checked="" type="checkbox"/> numbness	Arms Legs
<input checked="" type="checkbox"/> tingling	Arms Legs
<input checked="" type="checkbox"/> weakness	Has gotten better with time
<input checked="" type="checkbox"/> NEW bowel or bladder changes?	

When is your pain the worst?

☒ Morning ☐ Midday ☒ Evening ☒ Night

Have you tried any of the following for your current pain?

Did it help?

	YES	NO
Bracing	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>
Injectors	<input type="checkbox"/>	<input type="checkbox"/>
Medication	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Oral Steroids	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had any of the following?

<input checked="" type="checkbox"/> Heart attack
Hypertension
Chest pain (angina)
congestive heart failure
Atrial fibrillation
Asthma
COPD (emphysema)
Lung disease
Kidney failure/disease
Cirrhosis
Liver disease
Hepatitis A? B? C?
Diabetes insulin: Yes/No
Thyroid problems
Peptic ulcers
Stroke or TIA's
Seizures
Multiple sclerosis
Bleeding disorders
Sickle cell disease
HIV or immune diseases
Alcoholism
Drug addiction
Psychiatric disorders
Other:

Have you had surgery before?

	year?
Back surgery	
neck surgery/fusion	
lumbar spine surgery	
lumbar fusion	
Cardiac surgery	
bypass	
angioplasty	
pacemaker/AICD	
Hysterectomy	
appendectomy	
tonsillectomy	
cholecystectomy	
cancer surgery	
lung surgery	
brain surgery	
carpal tunnel release	
knee arthroscopy	
total knee replacement	
cesarean section	
breast biopsy	
Other:	

Do you have any of the following symptoms?

<input checked="" type="checkbox"/> abnormal bruising
<input checked="" type="checkbox"/> allergic rash
<input checked="" type="checkbox"/> anxiety
bleeding
chest pain
cold intolerance
confusion
constipation
cough
cramps
depression
diarrhea
diplopia - double vision
edema
<input checked="" type="checkbox"/> fatigue
fever
<input checked="" type="checkbox"/> headaches
hearing loss
heat intolerance
incontinence
indigestion/heartburn
<input checked="" type="checkbox"/> insomnia-sleep difficulty
<input checked="" type="checkbox"/> itching
joint pain
memory loss
nausea
<input checked="" type="checkbox"/> pain at night
<input checked="" type="checkbox"/> palpitations
<input checked="" type="checkbox"/> rash
recurrent infections
<input checked="" type="checkbox"/> restless legs
<input checked="" type="checkbox"/> sexual dysfunction
shortness of breath
sore throat
sweats
syncope - dizziness
tinnitus - ringing in ears
tremors
unusual weight gain
<input checked="" type="checkbox"/> unusual weight loss
<input checked="" type="checkbox"/> urinary frequency
urinary hesitancy
vertigo
<input checked="" type="checkbox"/> vision loss
<input checked="" type="checkbox"/> weakness
<input checked="" type="checkbox"/> wheezing

Name:

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Date of Birth:

07/26/1968

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