PATIENT NAME			<del></del>				
REASON FOR YOUR APPOINTM	ENT TODAY:		<b>17.1</b>				· · · · · · · · · · · · · · · · · · ·
w				····	· · · · · · · · · · · · · · · · · · ·		71 1. 7 1 2 1
······································	···			<del></del>			
			YES	NO	<del></del>	COMMENT	<u> </u>
Is this a result of an injury at w	ork?				·	COMMINITION	
Is this a result of an injury in a	- · · · · · · · · · · · · · · · · · · ·	e accident?			<del></del>	······································	·
Have you had an MRI?	THE RESERVE TO THE PERSON OF T	o accident.			· ····································		
Have you had a CT scan?					· · · · · · · · · · · · · · · · · · ·	<del></del>	···
Have you had a myelogram?							
Please check any prior treatmer	its that annly:	······································	Y		<u> </u>		· · · · · · · · · · · · · · · · · · ·
- physical therapy	its that apply.	<u> </u>		<del></del>	·	······································	
- chiropractic therapy	······································	······································		<del></del>	<del></del> -	<u> </u>	<del></del>
- steroid injections	<u> </u>	······································			<u></u>	· <u> </u>	<u>.</u>
- other (please describe)	<u></u>			<del></del> .	···	<del>-</del>	<u> </u>
· · · · · · · · · · · · · · · · · · ·	TRATION	TITAL CARIT	X FF X	7 <b>0</b> T T			
PLEASE COMPLETE THE TENTO FOR BACK D							ED OR
TREATED FOR BACK PA	ALL.	JIREK PA			EASE DISK	EGARD.	
		PAIN SYM	<b>IPTON</b>	1S	•		
TT ' 11 T T 11				_	_	•	
Using an "X", please man	rk on the li	ne below h	low m	uch p	ain you hav	e had from	ı your bacl
in the last seven days.							
•							
0 1 2	3	4 5	$\epsilon$	5	7 8	9	10
NO PAIN AT ALL		· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	······································		·	<del></del>
NOTAIN AT ALL						MAX	IMUM PAIN POSSIBI
In the past week how oft	ten have yo	ou suffered	<u>:</u> (ple	ase m	ark one bo	x per line)	
	None of	A little of	Son	ne of	A good bit	t Most of	All o
	The time	the time		time	of the time		<del>_</del> .
Leg pain?							
Numbness or tingling in	· .						
			,				
leg and/or foot?							
Weakness in leg and/or foot?							
In the most was all 1 1	. 41	!11		,		- <b>-</b> -	- <b>-</b>
In the past week, how bo	omersome I	nave tnese	sympt	oms	been! (plea	ise mark or	ie box per
line)							
•	Not at all	Slightly	Some	what	Moderately	Very	Extremely
	Bothersome	Bothersome	Bother	rsome	Bothersome	Bothersome	Bothersome
Leanain?							
Leg pain?							
Numbness or tingling in		<del></del>				, marine	
leg and/or foot?	<b>L</b>	L_J					
Weakness in leg and/or foot?							
Patient's Initials:		•					
1 autilitials.					Date:	· /	/
MD Signature:					Dail.	MONTH DAY	YEAR

p	Δ	T	F	TV	N	Δ	ME
l.	Λ	. <b>I</b>	لنبيا	A T	TA		

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PAST MEDICAL HISTORY	YES	NO	FAMILY HIS	STORY	COMMENTS
Lung Disease or Respiratory problems (emphysema, bronchitis, etc.)		-		)	
Tuberculosis		†		<u>,=</u>	
Persistent cough or cough that produces blood	-	<del> </del>			
Liver Disease	<del> </del>	<del>                        -     -</del>		<u> </u>	
Cardiovascular Disease (heart trouble, heart attack, pacemaker)	<del>                                     </del>			<u>-</u>	
Do you have high blood pressure?	<del> </del>				
Angina	<del> </del>				
Stroke					
Sinus trouble				<del></del>	
Fainting spells					
Recent weight loss					
Diabetes					
Hepatitis, jaundice or liver disease			1		· · · · · · · · · · · · · · · · · · ·
Thyroid problems				<u></u> !	
Arthritis or painful swollen joints					
Stomach ulcer or esophageal reflux			<u> </u>		
Kidney trouble					——————————————————————————————————————
Have you had abnormal bleeding?			<del></del> -		
Have you ever required a blood transfusion?					
Do you have a blood disorder such as anemia?			1		
Are you caustrophobic, a metal worker or have implants?			<u> </u>		
Are you pregnant?					
Are you taking birth control pills?					
Any history of epilepsy (seizure disorder)?			<del></del>		
Any history of Cancer?		1			
Have you ever been treated for mental illness?			<del></del>		
Are there any other medical problems that you are currently					
being treated for?		1			
Do you drink alcohol?	How	often?	<del></del>	<u></u>	<u></u>
Do you smoke?	ļ	often?			······································
Are you allergic to anything? (Please list specific allergies)					m
Please list any prior surgeries:					
		<del></del>		<del></del>	······································
			<u> </u>		<u> </u>
			······································		······································
Please list your current medications: **** We will be happy to	o copy	a med	lication list if ye	have one	
	Υ		How Often		
				11000	4 taking
					<del></del>
	<u> </u>				······································
	1				
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