NAME: _____ **DATE:** _____

MEDICAL HISTORY/QUESTIONNAIRE

1. Date of first symptom? _____
2. Where is your current pain/problem? _____
3. What was the circumstance or injury causing your current pain?

   _____
4. Which physicians have treated you for this current problem?

   _____
5. What treatment(s) have you had?

   _____
6. Have you had any surgeries for this (these) injury(s) and if so, what kind?

   _____
7. Have you worn any braces or orthotics for this problem?

   _____
8. Physical Therapy or other Rehabilitation program?

   _____
9. Which medications have/are you taking for this pain?

   _____
10. Is your pain constant (24 hours per day)?

    _____
11. Is your pain getting: WORSE BETTER STAYING THE SAME
12. What makes the pain worse?

    _____
13. What makes the pain better?

    _____
14. Have you had numbness, tingling or weakness?

    _____

    IF YOU HAVE SPINE PAIN: is it associated with arm or leg pain? _____
    Left-sided_____ right-sided _____

    What percentage of pain is in your back _____%, leg_____%, neck _____%, arm _____%

15. Have you had loss of bladder or bowel control?

    _____