

If you develop leg pain with walking, does leaning forward and supporting your upper body on something relieve your leg pains ó

() yes () no () do not develop leg pain with walking

NECK PROBLEM: (if this applies to you)

How many years / months / weeks ago did it start? _____

What date (approximately) did your problem begin? ____/____/____

Please circle how you injured yourself / how the pain started

Slip / direct impact / jerk / lift / twist / fall / bend / other car accident

Comments _____

- Your pain began () gradually () suddenly () from an injury
- Your pain is in () front of neck () back of neck () back and front
- It has lasted () weeks () months () years
- You have pain () occasionally () off and on () constantly
- The pain radiates () R arm () L arm () does not radiate
- You have tingling / numbness () R / L arm
- You have muscle weakness () R / L arm
- You have () headaches () blurred vision () changed hearing

Your pain is (check box)

- | <u>Worse</u> | <u>no different</u> | <u>better with</u> |
|--------------|---------------------|--------------------------|
| () | () | () coughing or sneezing |
| () | () | () straining at stools |
| () | () | () sitting straight |
| () | () | () sitting reclined |
| () | () | () standing |
| () | () | () sexual activity |
| () | () | () turning to R side |
| () | () | () turning to L side |
| () | () | () looking up |
| () | () | () looking down |

PLEASE DESCRIBE ANY OTHER SYMPTOMS YOU ARE HAVING:

TREATMENT

How long have you been treated so far? _____ months _____ years

You are () improved () no different () getting worse

With whom have you had your treatment so far ó

Providing source Treatment given

INVESTIGATIONS PERFORMED please list the tests done

<u>Test</u>	<u>approximate date</u>	<u>Center / Doctors office</u>
SPINE X-RAYS	_____	_____
CT SCAN	_____	_____
MYELOGRAM	_____	_____
MRI SCAN	_____	_____

EMG NERVE TEST _____
ARTHRITIS BLOOD TESTS _____
OTHER TESTS _____

MEDICATIONS: you currently take _____ for your (whatever) medical problem
_____ for your _____
_____ for your _____
_____ for your _____
_____ for your _____
_____ for your _____

ANY PAST NECK/BACK PROBLEMS () Yes () No () different
Previous motor vehicle accidents () Yes () No
Previous work injuries describe when () Yes () No
and who treated you.

PAST MEDICAL HISTORY:
What serious medical problems do you suffer from? Please list any surgeries you may have had for any problem.

COUNSELING: have you had or are you having any counseling, psychological or psychiatric treatment?
From date _____ till _____ For what reason?

JOB DESCRIPTION:
Have you had to take time off from work for this problem? () yes () no
Duration of time off from _____ to _____
Your job title _____
You are currently () working () not working () unemployed
Your last day worked _____
You are on () regular duty () modified duty
() full time () part time

Please see the other side

PLEASE DRAW A LINE OR MARK WHERE YOU THINK YOUR PAIN LEVEL HAS GENERALLY BEEN FOR THE LAST FEW DAYS:

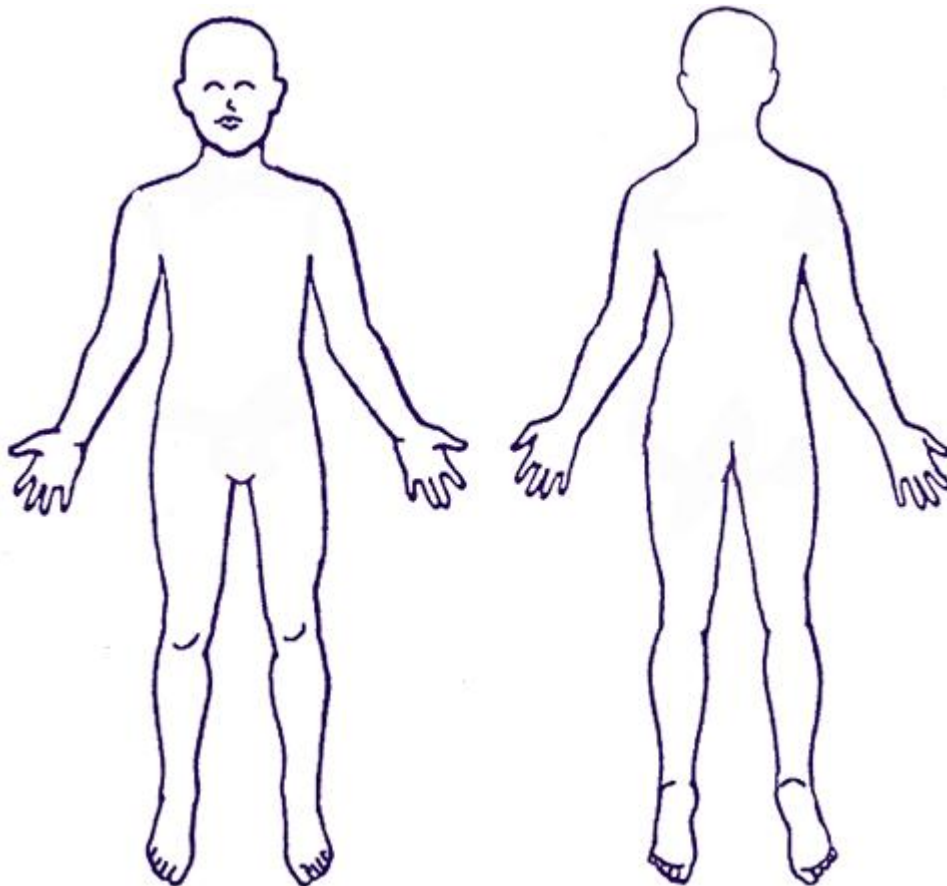
<u>NO</u> PAIN	<u>MINIMAL</u> PAIN							<u>SEVERE</u> PAIN		
0	1	2	3	4	5	6	7	8	9	10
										not tolerable

Your pain is: once / few hours once / few days once / few week or two
 once / few weeks occasional almost constant constant

PAIN DIAGRAM:

Please draw in wherever you are feeling any of the following symptoms ó use the following symbols:

PAIN (+) NUMBNESS (=) TINGLING (0) BURNING (X)



(Signature) _____