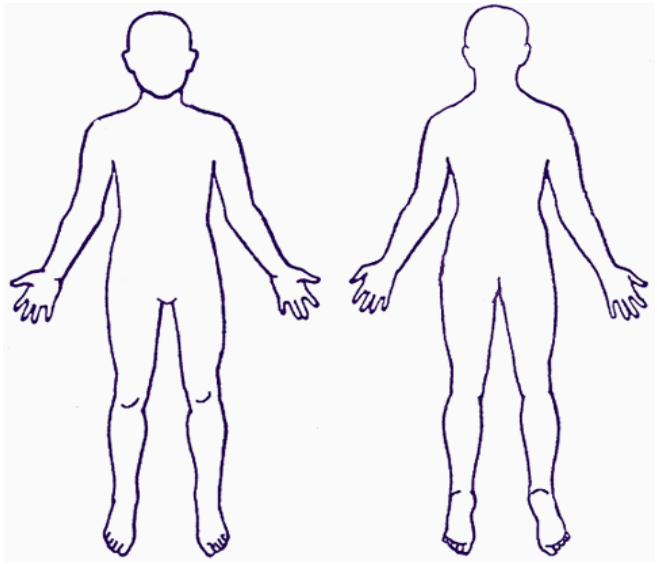
Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas.

Aches ^^^^ **Numbness** 0000 **Tingling** **** **Burning** xxxx **Stabbing** ////

What percentage of the day are you in pain? (Please circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Rate your pain on average: (0= no pain, 10= worst pain ever) 0 1 2 3 4 5 6 7 8 9 10



Do you have any difficulty with: (circle all that apply)

Numbness weakness early morning stiffness bowel bladder sexual function

Do you have any family history of:

Diabetes _____ Heart disease_____

Stroke _____ Cancer _____

Arthritis _____

Do you have difficulty in: ( ) standing ( ) sitting ( ) bending ( ) walking

Do you have pain radiating into your: ( ) right arm ( ) left arm ( ) right leg ( ) left leg

Do you have difficulty lifting: ( ) Light ( ) moderate ( ) heavy ( ) repeated lifting

Do you have symptoms radiating into: ( ) neck ( ) ribs ( ) shoulders ( ) base of skulls

What have you tried: ( ) drugs/meds ( ) heat ( ) cold ( ) rest ( ) exercise ( ) surgery ( ) massage

Has your problem interrupted your sleep? ( ) yes ( ) no

Does anyone in your family have the same or similar problems? ( ) yes ( ) no

Are you currently pregnant? ( ) yes ( ) no

Do you: ( ) smoke ( ) drink alcohol: rare some often ( ) exercise: light medium heavy

Signed: _____ Date: _____