Patient Name: _____ Date: _____

Reason for Visit: _____

_____

_____

Part of your body expereincing the GREATEST pain:

Pain Location: _____ Date of Onset: _____ Rated at (0 None, 10 unbearable): _____

Pain Location: _____ Date of Onset: _____ Rated at (0 None, 10 unbearable): _____

Pain Location: _____ Date of Onset: _____ Rated at (0 None, 10 unbearable): _____

The pain was: ☐ gradual ☐ sudden ☐ following an injury on: _____
Please indicate: ☐ no prior low back pain ☐ no prior leg pain ☐ no neck/shoulder pain ☐ no arm pain
Dominant hand: ☐ left ☐ right

Treatment History for Current Problem

Medications taken for current symptoms:

Steroidal Anti-inflammatories: ☐ Medrol dosepak ☐ Other: _____

Nonsteroidal Anti-inflammatories: ☐ Aleve ☐ Aspirin ☐ Motrin ☐ Celebrex ☐ Mobic ☐ Other: _____

Pain relievers: ☐ Tylenol ☐ Darvocet ☐ Tramadol ☐ Ultram ☐ Norco ☐ Vicodin ☐ Other: _____

Muscle relaxers: ☐ Flexeril ☐ Skelaxin ☐ Soma ☐ Other: _____

Have you had physical therapy for this problem? ☐ No ☐ Yes Date of last session: _____

Please check any injection treatment(s) received for this problem:
☐ Epidural steroid ☐ Facet ☐ Trigger Point ☐ Nerve Root Block ☐ Other: _____

Medication	Dosage	Time of Day