LIST ANY OF THE FOLLOWING TREATMENTS YOU HAVE HAD FOR YOUR PAIN AND ALL MEDICATIONS YOU HAVE TAKEN. ***PLEASE STATE HOW LONG YOUR TREATMENTS LASTED.***

(CIRCLE ALL THAT APPLY)

PHYSICAL THERAPY *describe*____

BED REST *describe*____

CHIROPRACTIC TREATMENT *describe*____

HOSPITALIZATION *describe*____

MEDICATIONS *describe*____

____

What was the last date you were able to work?____________________________________

List ALL days of work you have missed____

PLEASE INDICATE WITH AN (X) WHAT EFFECT THE FOLLOWING HAS ON YOUR PAIN

	no effect	*more pain*	*less pain*
Rest			
Moving about			
Coughing/sneezing .			
Lifting			
Weather changes. . .			
Menstrual period. . . .			

For Physician Use Only

Motor ___________

Sensory __________

Reflex ___________

Describe any other information that you think may be useful to your doctor:____________________

____

____

____

____

____

Signature of patient or responsible party.

Medical Systems
(256) 539-7320