PATIENT HISTORY UPDATE

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Date_____

If there has been a change in your address, please update below:

Address _____ City _____ State _____ Zip _____

Please describe in your own words the new condition you are experiencing:

How long have you had this condition?

Have you had this or similar conditions in the past

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine

Other

Other doctors or therapist who have treated THIS condition:

What do you think caused this condition

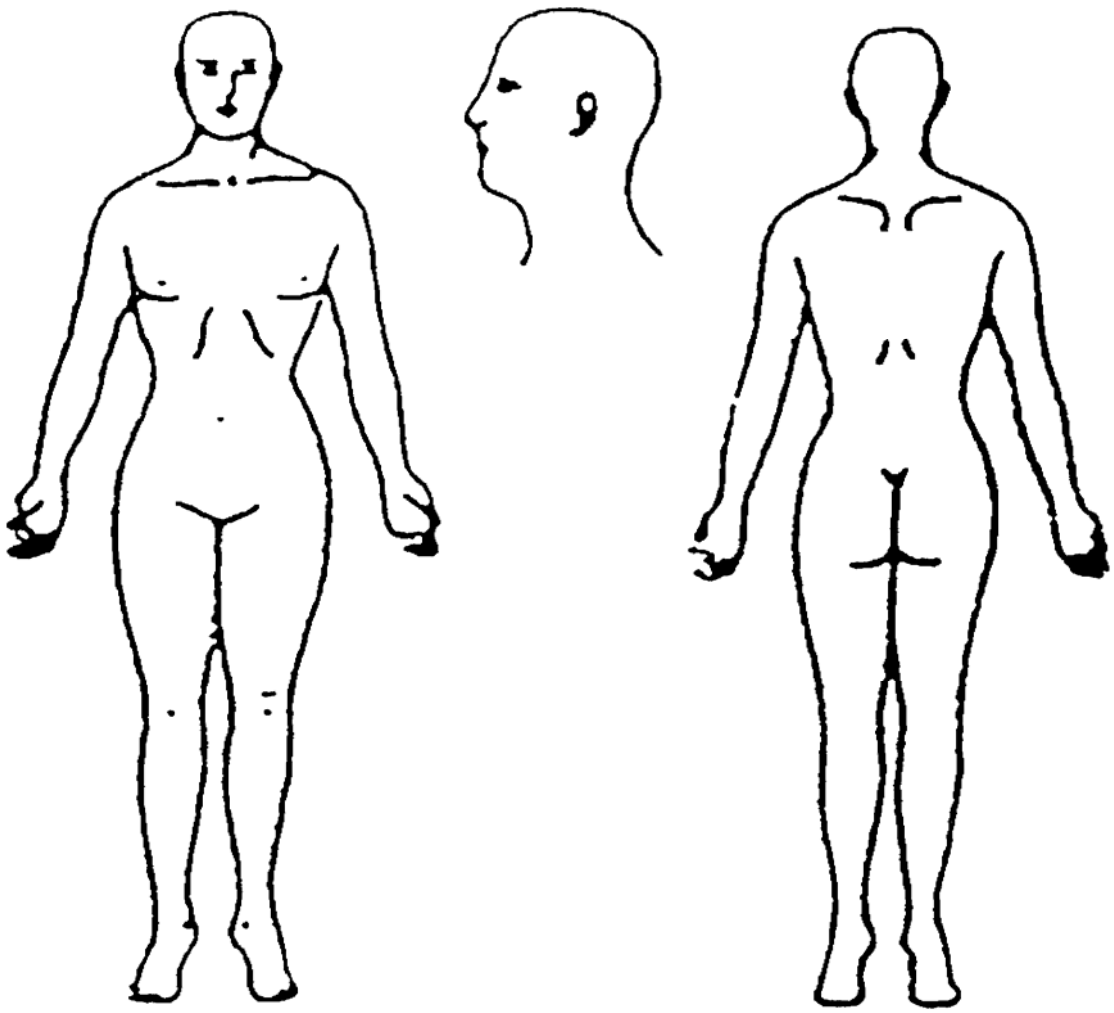
Signature _____ Date _____

Parent/Guardian _____ Date _____

Name _____ Date _____

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. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ●●●● Burning xxxx Stabbing ////



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Reference: Randsford. Spine, Vol. 1, No 2, June 1976