

## **Initial Visit Questionnaire**

1. Please circle the reason for your visit today:  PAIN WEAKNESS NUMBNESS STIFFNESS SWELLING 2. Where are your symptoms located? (Please mark "X" for pain and "O" for numbness/tingling)  BACK FRONT  LEFT LEFT  4. Did you have an injury or a fall?	ORTHO SPINE AMERICA	NAME		DOB	DATE
2. Where are your symptoms located? (Please mark "X" for pain and "O" for numbness/tingling)  BACK FRONT  LEFT RIGHT RIGHT LEFT  4. Did you have an injury or a fall? If yes, is the injury work related?  5. Are your symptoms a result of an automobile accident?  6. What is your current pain level? (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)  7. Describe your pain: BURNING DULL SHARP STABBING THROBBING  8. Are your normal daily activities restricted due to your current symptoms?  9. What exacerbates your pain?  10. What relieves your pain?  11. Have you had treatment for this problem prior to today's visit?    CROWLED CONTINUE CONTIN			Ht	Wt	BP
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□ ER □ PHYSICIAN □ INJECTION □ PT □ SURGERY □ OTHER □ 12. Were the treatments helpful? □ 13. Are you currently taking any medications for this problem? Please list: □ 14. Have you had any diagnostic studies including X-rays, MRI, CT scans or nerve conduction studies? □ Where? □ 15. Are you being treated for any chronic medical conditions? □ 16. Are you currently taking blood thinning medications? □ 17. What is your present work status? □ 17. What is your present work status? □ 18. Are you carrently taking blood thinning medications? □ 19. What is your present work status? □ 19. What is your present work status what is your present white your present white your present white yo	10. What relieves your pai	n?			
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