

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Please indicate if these symptoms are the result of the following:*

Auto Accident ( )                      Injury ( )                      Illness ( )

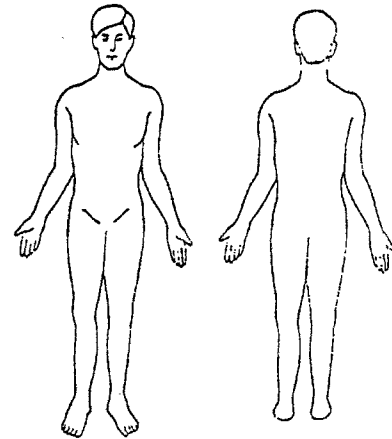
When did your symptoms start or accident happen: \_\_\_\_\_

Please answer all questions that pertain to today's examination.

YES	NO	Do you experience or have the following?		
( )	( )	Previous surgery to your spine	Where: _____	When: _____
( )	( )	Cervical (neck) pain		
( )	( )	Thoracic (mid back) pain		
( )	( )	Lumbar (lower back) pain		
( )	( )	Headache		

YES NO Please indicate the body location that you experience symptoms.

( )	( )	Shoulder, Elbow, Hand, Wrist, Fingers	Right	Left
( )	( )	Buttock (s), Hip, Leg, Knee, Ankle, Foot, Toes	Right	Left
( )	( )	Weakness?		
		Where: _____		
( )	( )	Paralysis?		
		Where: _____		
( )	( )	Loss of Sensation?		
		Where: _____		
( )	( )	Tingling and / or Prickling?		
		Where: _____		
( )	( )	Tremor or Spasm?		
		Where: _____		
( )	( )	Lack of Coordination?		
( )	( )	Difficulty in walking or limp?		
( )	( )	Mass, swelling, lump?		
		Where: _____		
( )	( )	Abnormal Posture?		
( )	( )	History of Multiple Sclerosis?		



Other symptoms or complaints: \_\_\_\_\_

( ) ( ) Have you ever had any prior Xrays, CT Scan, Ultrasound or Nuclear Medicine exams for this area?  
Where: \_\_\_\_\_ When? \_\_\_\_\_

( ) ( ) Have you had cancer? Type: \_\_\_\_\_  
What was done?                      Surgery                      Chemotherapy                      Radiation Therapy  
Date of Surgery: \_\_\_\_\_ Date of therapy: \_\_\_\_\_