Check appropriate symptoms, circle ONE dominant issue:

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Pain</td>
<td>☐ Pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leg</th>
<th>Arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Pain</td>
<td>☐ Pain</td>
</tr>
<tr>
<td>☐ Weakness</td>
<td>☐ Weakness</td>
</tr>
<tr>
<td>☐ Numbness/Tingling</td>
<td>☐ Numbness/Tingling</td>
</tr>
</tbody>
</table>

**Total Duration of symptoms:**

______ ☐ weeks ☐ months ☐ years

**Do you currently take narcotics?** ☐ Yes ☐ No

How long have you been taking this medication?

______ ☐ weeks ☐ months ☐ years

**Physical Therapy**

Currently ☐ Yes ☐ No

How long have/did you attend?

______ ☐ weeks ☐ months ☐ years

**Are you currently taking anti-inflammatories?** (Examples: Ibuprofen, Aspirin)

☐ Yes ☐ No

**Other treatments (check all that apply):**

- Massage
- Heat
- Ice
- Acupuncture
- Traction
- Chiropractic
- Other: _________________________

**Past Surgical History (check all that apply):**

- Surgery
  - ☐ Decompression
  - ☐ Fusion
  - ☐ Unknown

**Previous Surgeon(s):**

__________________________

- Injection
  - ☐ Epidural
  - ☐ Facet
  - ☐ RFA Ablation
  - ☐ Trigger point
  - ☐ Unknown

**Surgery/Injection**

Level(s):____________________

**Location:**

- ☐ Lumbar (low back)
- ☐ Thoracic (mid-back)
- ☐ Cervical (neck)