

### HISTORY OF EVALUATION

List all the physicians you have seen related to your pain problem:

Physician's Name	Type of Doctor	Phone/Fax #

What have you been told is causing your pain?

Physician's Name	Type of Doctor	What did the doctor tell you?

Please list any surgeries you have had related to your pain problem:

Surgery	Date of Surgery	Physician

Diagnostics/Tests (Check ones that apply to you)

	Date of Test	Results of Test
<input type="checkbox"/> X-rays		
<input type="checkbox"/> MRI		
<input type="checkbox"/> Myelogram		
<input type="checkbox"/> EMG/Nerve Test		
<input type="checkbox"/> CT Scan		
<input type="checkbox"/> Bone Scan		
<input type="checkbox"/> Discogram		