

TREATMENT RELATED TO SYMPTOMS

	Date	Results
<input type="checkbox"/> Trigger Point Injections		
<input type="checkbox"/> Epidural Injection		
<input type="checkbox"/> Block/ Type _____ (facet block, nerve block, sympathetic block etc)		
<input type="checkbox"/> Procedure/Type _____ (radio-frequency, dorsal column stimulator, pump etc)		
<input type="checkbox"/> Biofeedback Therapy		
<input type="checkbox"/> Chiropractor		
<input type="checkbox"/> Other (acupuncture, etc)		

MEDICATIONS RELATED TO YOUR CURRENT PAIN (Include sleep, anxiety and depressions medications)

Medication Name	Dose	Times per Day	Doctor Prescribing

OTHER MEDICATIONS

Have you tried any of the following medications? (Check all that apply)

Neurontin Ultram Elavil Lidoderm Patch Zanaflex Other

List **any other medications** you are taking for a **non-related problem** _____

LEVEL OF FUNCTION PRIOR TO YOUR PAIN PROBLEM

How would you describe your level of function **BEFORE** your symptoms/pain began? _____

Please list your hobbies and/or activities which you are **NOT** able to do because of pain _____

Have you undergone Physical Therapy related to your current pain problem? YES NO

If YES, please complete the following

Are you currently receiving treatment? YES NO Last date of treatment _____

Approximate number of physical therapy sessions _____

Please check the following modalities/treatments that you have received

<input type="checkbox"/> Hot/Cold Packs	<input type="checkbox"/> Traction	<input type="checkbox"/> Massage
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> TENS Unit	<input type="checkbox"/> Aerobic Program
<input type="checkbox"/> Electric Stimulation	<input type="checkbox"/> Stretching	<input type="checkbox"/> Back School
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Trunk Stabilization Program	<input type="checkbox"/> Manipulation

Please list any of the above modalities or exercises that you are still using _____