SPINE FORM

·	AY'S DATE
3. Are you still able to work? Yes No Occupation	
E.D. U'	
4. How did the pain start? a. Suddenly () g. Injured at work () b. Sitting b. Gradually () h. Auto Accident () c. Standing c. Lifting () i. Hit in Back () d. Walking d. Twisting () j. Sports () e. Physical e. Fall () k. No apparent cause () f. Pain Pills f. Bending () l. Other () g. Muscle r. h. Aspirin i. Arthritis p	() () () () () () () () () () () () () () ()
6. How long have you had any back pain? How long have you had any neck pain? How long have you had any leg pain? How long have you had any arm pain? Years Months Years Months	Weeks Weeks
7. Do vou have weakness in your legs or arms?	
YesNo If yes, describe	
No Lave you had neck or back surgery? YesNo	
Number of times Dates:	
Mark the areas of your body where you feel the described sensations. ACHE <<< NUMBNESS 00000 BURNING XXXXX STABBING // RIGHT LEFT LEFT	PINS & NEEDLES ++++++ RIGHT
FRONT Plages mark on the line: How had is your peek/hook n	BACK
Please mark on the line: How bad is your neck/back p	
Please mark on the line: How bad is your neck/back p. 01_2_3_4_5_6_7_8_910	