Consultation

NAME: ______________________________ DATE: ________________

Height:

Weight:

WHEN FIRST NOTICED SYMPTOMS:

HAS IT HAPPENED BEFORE:

WORSE/BETTER AM/PM:

ANY RADIATION OF PAIN, NUMBNESS OR TINGLING DOWN ARMS OR LEGS:

ANY POSITION RELEIVES:

LOCATION OF PAIN:

FREQUENCY:

DURATION:

OTHER DOCTORS SEEN:

WHAT HELPS PAIN:

SURGERY RECCOMMENDED:

CURRENTLY TAKING ANY MEDICATIONS:

ANY DIZZINESS: