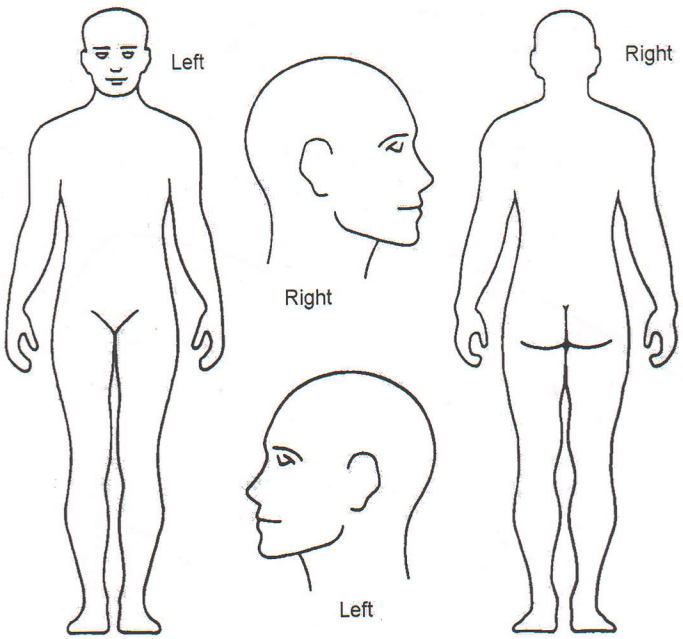
Health Survey

As related to your condition, mark the areas of pain



Please describe your condition:

_____

_____

_____

_____

_____

What medication(s) did, or are you currently taking for this condition? _____

_____

Did you take any time off of work? _____

If yes, how many day(s) / dates _____

_____

Work Limitations: _____

_____

_____

If the following condition(s) apply please mark with the following letters:

O = Occasional **F = Frequent** **C = Constant**

_____ Vomiting
_____ Nausea
_____ Dizziness
_____ Vision Problems
_____ Change in Appetite
_____ Change in Sleeping Habits
_____ Concentration Problems
_____ Headaches
_____ Chest Pain
_____ Neck Pain
_____ Shoulder Pain (right / Left)
_____ Arm Pain (right / left)
_____ Pain Radiating down arm(s)
_____ Upper Back Pain
_____ Mid Back Pain

_____ Low Back Pain
_____ Pain Radiating down leg(s) (right / left)
_____ Hip / Thigh Pain (right / left)
_____ Knee Pain (right left)
_____ Ankle / Foot Pain (right / left)
_____ Problems walking
_____ Painful joints
_____ Stiff Joints
_____ Other: _____

_____

_____

Females only: Are you pregnant? Yes / No

Signature_____

Date_____