PATIENT MEDICAL HISTORY FORM (Continued)

Are you taking any medications presently?  NO_____  YES_____  If so, please list: ______________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

13. Describe the nature of your problem and indicate on diagram where: ______________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Please indicate your CURRENT pain level on the chart below:

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<td>No Pain</td>
<td>Moderate Pain</td>
<td>Worst Pain</td>
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14. What if any treatments have you had for this current problem? ___________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Did they help?  Yes____  No____

15. What in particular makes your pain worse? ___________________________________________________________

__________________________________________________________________________________________________

16. What, if anything, eases the pain? __________________________________________________________________

__________________________________________________________________________________________________

17. Can you get comfortable at night?  Yes____  No____

18. How do you feel upon rising?  Stiff____  Sore____  Fine____

19. Once you start moving about, does it worsen____ or ease____?

20. What is it like at the end of the day?  Worse____  Easier____

21. Do you have any pins and needles, etc?  Yes____  No____ (if yes, please indicate location on diagram above)

22. At this time, do you consider you are getting better____, worse____ or stable____?

Please rate your ability to perform the following activities:
1-Not Limited  2-Can do with some difficulty  3-Can do with significant difficulty  4-Can’t do at all

Sleeping____  Dressing____  Sitting____  Standing____  Walking____  Housework____

Driving____  Stairs____  Sporting Activities____  Sexual Activity____  Yardwork____

WHAT GOALS DO YOU WANT TO ACHIEVE WITH THERAPY?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Patient Signature:____________________________________  Date:__________________________________