

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

<p>NECK</p> <p><input type="checkbox"/> Pain in neck</p> <p><input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> Neck weakness</p> <p><input type="checkbox"/> Pinched nerve in neck</p> <p><input type="checkbox"/> Neck feels out of place</p> <p><input type="checkbox"/> Muscle spasms in neck</p> <p><input type="checkbox"/> Grinding/popping sounds in neck</p> <p>SHOULDERS Right Left</p> <p><input type="checkbox"/> Pain in shoulder joint <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain across shoulders</p> <p><input type="checkbox"/> Can't raise arm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p style="padding-left: 20px;"><input type="checkbox"/> Above shoulder level</p> <p style="padding-left: 20px;"><input type="checkbox"/> Over head</p> <p><input type="checkbox"/> Tension in shoulders</p> <p><input type="checkbox"/> Pinched nerve in shoulder <input type="checkbox"/>R <input type="checkbox"/>L</p> <p>MID-BACK</p> <p><input type="checkbox"/> Mid-back pain</p> <p><input type="checkbox"/> Mid-back stiffness</p> <p><input type="checkbox"/> Pain between shoulder blades</p>	<p><input type="checkbox"/> Pain from front to back</p> <p><input type="checkbox"/> Muscle spasms in mid-back</p> <p>ARMS & HANDS Right Left</p> <p><input type="checkbox"/> Pain in upper arm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in elbow <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in forearm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in hand <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in fingers <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pins & needles in arm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pins & needles in fingers <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Numbness in arm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Numbness in fingers <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Weakness of arm <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Weakness of hand <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Hands cold <input type="checkbox"/>R <input type="checkbox"/>L</p> <p>LOW BACK</p> <p><input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> Low back stiffness</p> <p><input type="checkbox"/> Low back weakness</p> <p><input type="checkbox"/> Pinched nerve in low back</p>	<p><input type="checkbox"/> Low back feels out of place</p> <p><input type="checkbox"/> Muscle spasms in low back</p> <p>HIPS, LEGS & FEET Right Left</p> <p><input type="checkbox"/> Pain in buttocks <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in hip joint <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain down leg <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in knee <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in ankle <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Pain in foot <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Weakness of leg <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Weakness of knee <input type="checkbox"/>R <input type="checkbox"/>L</p> <p><input type="checkbox"/> Leg cramps <input type="checkbox"/>R <input type="checkbox"/>L</p> <p>OTHER SYMPTOMS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Reviewed by _____	Date _____
Patient Signature	Date
Doctor	Date