Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

How would you describe your pain?

Sharp Dull Achy Stiff Shooting Burning Tight Numb Tingly

In general, how would you rate your overall health?

Excellent Very Good Good Fair Poor

What kind of regular exercise do you perform?

Strenuous Moderate Light None

Do you have an immediate family member with any of the following?

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus ALS

Have you had any major or recent surgical procedures?

If so, please list them here.