REDDING SPINE & SPORTS MEDICINE

Name: _____

DOB: _____

Today's Date: _____

What symptoms are you having?

□ Pain Where? _____

Does it Radiate? □ Yes – Where to? _____

□ No

□ Numbness / Tingling Where? _____ for how long? _____

□ Weakness Where? _____ for how long? _____

How did these symptoms begin? _____

_____

Do you have any of the following medical conditions/treatments?

□ Diabetes
□ Hypothyroidism
□ Hyperthyroidism
□ Kidney disease
□ Current or previous alcoholism or heavy alcohol use
□ Current or previous exposure to industrial toxins
□ HIV / AIDS
□ Recent severe illness requiring hospitalization
□ Gastric Bypass
□ Cancer
□ Chemotherapy
□ Radiation Therapy

Please list any other medical problems:

_____ _____

_____ _____

_____ _____

_____ _____

Please label the below diagrams with your symptoms:

Pain	Numbness	Tingling	Weakness
PPP	NNN	TTT	WWW