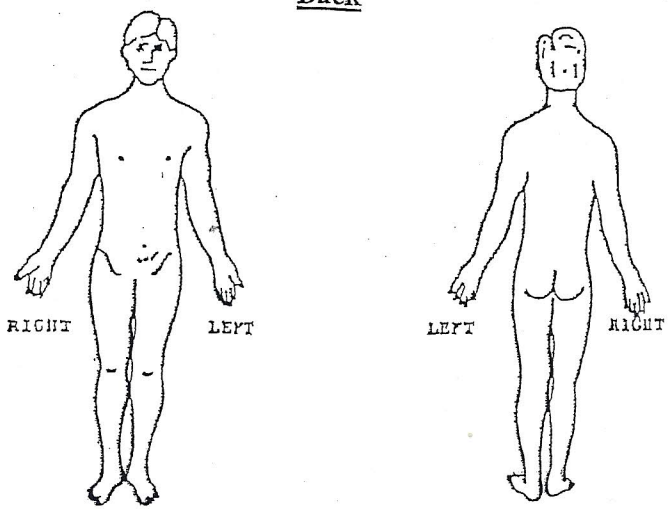
Patient # _____

Date _____

Back



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

_____

Is this a result of an injury? **YES** ____**NO** ____ If YES, give the date? _____(month-day-year)

If YES, how and where did your injury occurred:_____

_____

Is this work related? **YES** ____**NO** ____

If this was not an injury, how long have you been experiencing your symptoms?_____

Do you feel a lump in the area we are examining? **YES** or **NO** (circle) If YES, please describe how it feels to you. (hard, soft, does it move around, is it close to the surface or does it feel deep?) _____

_____

Are you having bowel or bladder problems? **YES** ____ **NO** ____ If YES, please describe your symptoms.

_____

Is there discoloration of the area? **YES** ____ **NO** ____ If YES, please describe. _____

_____

Have you had previous surgery on the effected area? **YES** ____ **NO** ____ If YES, what kind of surgery & when? _____

Have you had x-rays, CT scans or MRI scans for *this* problem? **YES** ____ **NO** ____ If YES, where were they done, when, and what did they show? _____

_____

What has your doctor told you about this problem? _____

_____

Do you have a history of cancer? **YES** ____ **NO** ____ If YES, what type? _____

Are you currently being treated? _____

Please give us your **HEIGHT** _____ **WEIGHT** _____