

Previous treatments for current symptom(s)

Treatment type	Effect on symptoms	Times/frequency/Dates
Physical Therapy	<input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worse	
Chiropractor	<input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worse	
Medications	<input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worse	
Injections	<input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worse	
Other:	<input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> Worse	

Other pertinent medical information: