It is important that this form is completed in full and brought with you to your first appointment

<u>NAME:</u> <u>DOB:</u> Please explain the reason for your visit (e.g. back pain/unable to reach up, etc.)

Where does your pain occur? (Please mark on the diagram below with an 'X')



<u>Please score each area of pain (on the diagram) from: 0 (No pain) to 10 (Extreme pain)</u> <u>Please mark on the any areas of numbness or pins and needles with an 'O'</u>

Approximately how long have you been suffering with this pain? (Please circle one)

Less than	1 week to		More than	More than
<1 week	1 month	1-3 months	3 months	1 Year >

What caused your pain? (E.g. Car crash, fall, repetitive movement, sport, unknown, etc.)

What activities worsen the pain? (E.g. bending, heavy lifting, sneezing, reaching up, etc.)	What relieves your pain? (E.g. Pain killers, hot water bottle, stretching, etc.)

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NAME:

DOB:

Have you had any previous treatment for this problem? (If yes, please provide details below)

Please rate your pain on severity from 0 (No pain) to 10 (Extreme pain), at these different times of the day: (Please circle)

Morning	Afternoon		Evening	
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7	8910	0 1 2 3 4 5	6 7 8 9 10
Has the pain affected your sleep in any way? YES NO				
Have you had any investigations E.g. X-Ray, MRI scan, ultrasou If yes, please provide details be	YES	NO		

Have you noticed any of the following: (Please circle)

1. Unexplained weight loss	YES	NO
2. Abnormal bowel or bladder function	YES	NO
(E.g. constipation/diarrhoea/urinary incontinence/retention)		
3. Muscle Weakness	YES	NO
(E.g. dropping things/dragging your feet)		
4. Difficulty Speaking	YES	NO
(E.g. slurred speech, difficulty finding the right words)		
5. Double Vision	YES	NO
6.Fainting or Dizziness	YES	NO

What do you do for a living?	List any regular sports or hobbies that you do		