

NAME:

DOB:

TODAY'S DATE:

PLEASE FILL OUT COMPLETELY PRIOR TO SEEING THE DOCTOR:

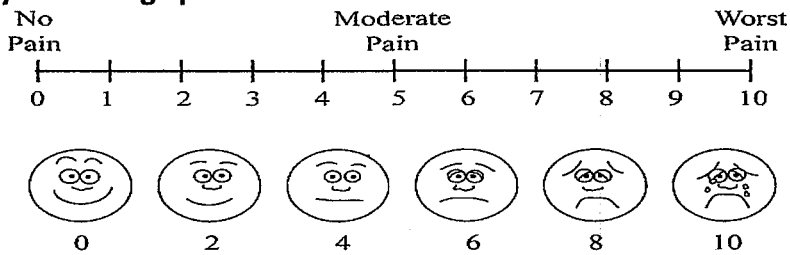
S) SYMPTOMS: (Please do not LIST symptoms; describe in **DETAIL**)

If PAIN is a prominent feature, is it (check all that apply):

Sharp/Stabbing Burning Numb Pins & Needles Dull/Aching Constant Intermittent (comes & goes)

Other (describe):

Please rate (circle) your average pain since last visit:



Do Not Write In This Space: Location: Timing:

What causes your symptoms to **worsen**?

Medicines Stretching Exercising Rest Heat Cold Weather changes Unknown Nothing Other (describe):

What causes your symptoms to **improve**?

Medicines Stretching Exercising Rest Heat Cold Weather changes Unknown Nothing Other (describe):

What can you do now that you couldn't do before your last treatment (or do better or with less pain)? Nothing

Do you have or have you had any **CHANGE** in numbness, tingling, or weakness since your last visit? (Describe) No

Changes in activity level? (Increased/decreased exercise, lifting, increased sitting/computer, etc.) None

Recent traumas? (Slips, trips, falls, near-falls, etc.) Please describe in detail: None

ROS: Have you been ill or had any changes in your health since last being seen by Dr. Cohn? None

Have you had any recent problems with your eyes, ears, nose mouth, or throat? Please, describe. None

Have there been any significant changes in the health of any family member since last visit to Dr. Cohn? (Describe) None