NAME: **DOB:** **TODAY'S DATE:**

***PLEASE FILL OUT* COMPLETELY *PRIOR TO SEEING THE DOCTOR*:**

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

_____

_____

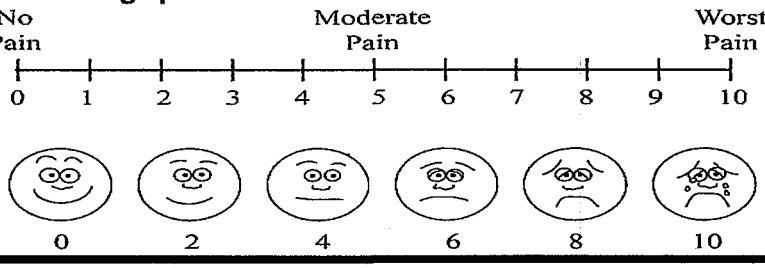
_____

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? ☐No

(Describe)_____

_____

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? ☐None

(Describe)_____