Please print and fill out form.

First and last name, age_____

What is your problem?_____

_____

How long have you been suffering?_____

What happened?_____

Are you getting worse?_____

Which activities aggravate your problem?_____

_____

Do your symptoms worsen as the day goes on? Yes___No___

Have you had anything simular in the past? _____

Have you been diagnosed previously? If yes what is it? _____

_____

Have you had surgery?_____

How often do you go to the dentist?_____

Do you sleep face down in bed? Yes___No___

Have you ever had a whiplash like injury? If yes, when?_____

Have you had other traumas? If yes, when?_____

How much time do you spend seated at home, in the car or at work?_____

Use pharmaceuticals? (specify which ones) _____

_____

Other disturbances? _____

_____

Indicate <u>exactly</u> where you feel pain or other symptoms