

Clinical Symptoms Intake: Please check **ANY** of the following symptoms that you may have.

<u>Symptoms</u>	<u>Side of the Body</u>		
	Both Sides	Left Side	Right Side
<u>Back Pain</u>			
Pain in your lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Leg Pain</u>			
Pain or burning in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Foot Pain</u>			
Pain or burning in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pins and needles in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sensitivity to touch in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling hot or cold in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling your feet when you walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort or pain at night in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Wrist, Hand or Finger Pain</u>			
Burning in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gripping things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty forming a fist with your hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in hands wakes you up at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neck Pain</u>			
Burning in your neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in your neck wakes you up at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coldness in your neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have **NONE** of the symptoms listed above

Patient's Signature

Date