Neuro-Musculo-Skeletal and Health Screening Questionnaire

Name_____ Male___ Female___Age____ Date_____

Do you suffer from any of the following? Place a check mark to indicate yes:

1. Low back pain_____
2. Low back pain with radiation to buttocks_____
3. Sciatic pain down leg to knee, calf or foot_____
4. Pain between the shoulder blades_____
5. Neck pain_____
6. Neck-shoulder-arm (hand pain or tingling)____
7. Tension Headache or Migraine Headaches____
8. Knee pain___ If yes briefly explain_____
9. Shoulder pain___ If yes briefly explain_____
10. Elbow pain___ If yes briefly explain_____
11. Hip pain___ If yes briefly explain_____
12. Shin splints___ If yes briefly explain_____
13. Plantar Fascitis___ If yes briefly explain_____
14. Muscle or Tendon Strain Injury___ If yes briefly explain_____
15. Ligament Damage___If yes briefly explain_____
16. Do you wear orthotics_____ If yes how many yrs old are they?_____
17. Any other muscle or joint problem____ If yes please explain_____

In the space below, feel free to further explain any muscle, bone, joint, cartilage, ligament or spinal problem you have had in the past, is currently bothering you, or is a recurring problem for you:_____
_____
_____
_____

See Other Side Of Form

Surgeries: List Any Surgeries You Have Had and The Year Performed:

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Medications: List All Medications You Are Currently Taking

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Supplements: List All Supplements You Are Currently Taking

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