Name: _____
Last *First* *Middle Initial*

Age: _____ Date: _____

X-RAY Evaluation

1. What was your chief complaint when you visited your doctor?

_____

2. Describe your symptoms (e.g., burning, sharp, etc.) _____

_____

3. a. Does anything make the pain worse (e.g. standing, sitting, lying down, etc.)?_____

b. Does anything make it better?_____

_____

4. Have you had surgery? _____

When?_____

What was done?_____

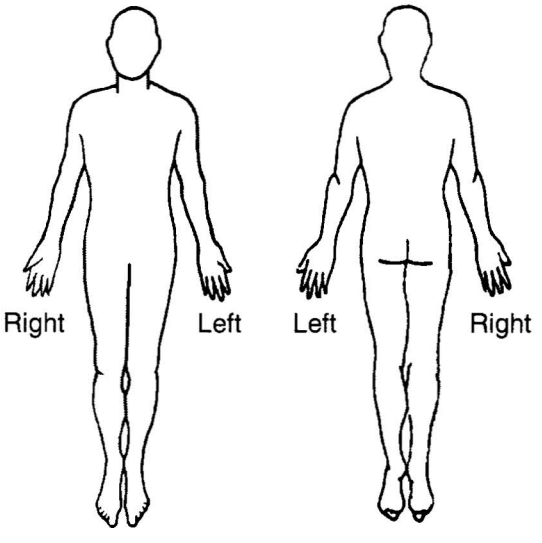
_____

5. Are you taking any medicines? _____

What kind? _____

6. Do you have any other medical conditions? _____

_____

_____

Please shade in areas of pain in picture below