

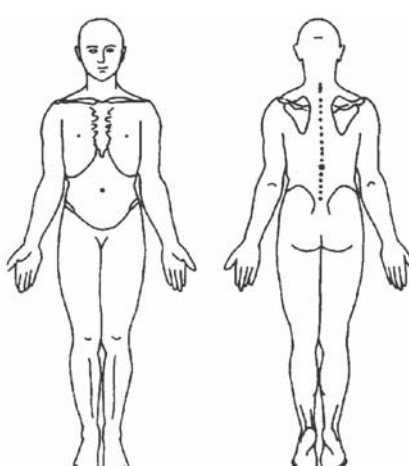


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Name:	Age:	Date:			
1. Since my last visit, my symptoms are (please check one):					
<input type="checkbox"/> Unchanged	<input type="checkbox"/> Improved. Describe: _____	<input type="checkbox"/> Worsened. Describe: _____			
2. Since we last saw you have you:					
Had any new problems? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
Seen any other physicians? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
Had any other treatments? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
Had any diagnostic tests? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
Had a change in your physical limitations? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
Had a change in your work status? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:					
3. Provide the following for all the medications that are being prescribed to treat your pain:					
Medication	Dosage/Frequency	Prescribed By	Medication	Dosage/Frequency	Prescribed By
1.			4.		
2.			5.		
3.			6.		
4. Please mark the location(s) of your pain on the body outlines using the symbols below.					
===== Pins & ===== Needles	XXXX Numbness XXXX	ZZZZZ Stabbing ZZZZZ	/// /// /// Aching & /// /// /// Cramping	BBBB Burning BBBB Sensation	
			<p>Place a mark on the line that represents your level of pain TODAY</p> <p>1-----10</p> <p>Place a mark on the line that represents your level of pain IN THE LAST WEEK</p> <p>1-----10</p>		