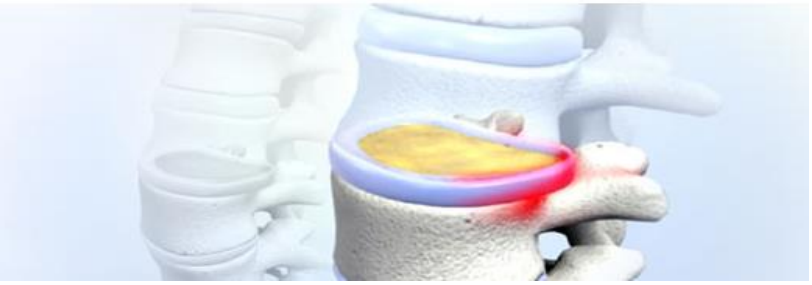
DISC-covery

Disc Recovery Program

4867 Munson St NW, Canton, OH 44718

Call: (330) 494-5533



**Name**: _____ **DOB**:_____ **Appointment Date:**_____

**What is your chief complaint?** Neck pain Arm Pain ( Right Left ) Low Back Pain Leg Pain ( Right Left )

Other: _____

**How long have you suffered with these symptoms?** _____

**How would you describe your pain?** Aching Dull Numbing Sharp Shooting Throbbing Tingling

**Please describe your symptoms:**_____

**Does it radiate or travel into another part of the body?** Yes No If so, where:_____

**Pain scale evaluation (Circle your pain level):** No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Intense Pain

**When is the pain worst (Circle your response):** Morning Mid-day Evening

**Family history of similar conditions?** Yes No

**Any weakness in arms or legs?** Yes No Arms Legs Right Left Both

**Poor circulation in arms or legs?** Yes No Arms Legs Right Left Both

**Blurred vision or change in eye function?** Yes No Right Left

**Dizziness or balance issues?** Yes No Dizziness Poor balance Both

**Do you suffer from any of the following:** ***Circle all that apply***

Chronic sinus issues Low grade fever Unexplained Weight loss Night sweats

Issues with fatigue Bowel/bladder changes or loss of control Male/Female disorders

Other/Details: _____

**Previous Care:** **Date/Details** **Date/Details**

Pain Management:_____ Surgery:_____

Physical Therapy:_____ Chiropractic:_____

Medication:_____ Acupuncture:_____

Other: _____

Any treatment success? _____

**Previous Imaging: Please bring copies of your images and reports to your consultation appointment**

**MRI:** Yes No Area:_____ Date:_____

**Xrays:** Yes No Area:_____ Date:_____

**CT scan:** Yes No Area:_____ Date:_____

**Details/Findings:**_____

**Other information we should know:**_____

_____