Thoracic Spine Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME
LAST NAME
AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

WHAT DO YOU THINK CAUSED THE PROBLEM?

DO YOU HAVE ANY NUMBNESS, WEAKNESS OR PAIN? ☐ YES ☐ NO
IF YES, WHERE?

HAVE YOU HAD SPINE SURGERY? ☐ YES ☐ NO
IF YES, WHEN AND WHAT WAS DONE?

ANY OTHER MEDICAL CONDITIONS? ☐ YES ☐ NO

DESCRIBE YOUR GENERAL HEALTH?

Please circle the portion of your body that is in pain.