GLOBAL
INTEGRATIVE MEDICINE ACADEMY

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:_____

_____

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See Other Side Of For

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

Medications: List All Medications You Are Currently Taking

Supplements: List All Supplements You Are Currently Taking