Pre-Exam Questionnaire-POST SURGERY
SYNERGY Therapeutic Group

1. On what part of the body did you receive surgery?

2. When was the surgery? ___/___/20___

3. Why did you need surgery?

4. When was your most recent X-ray? ___/___/20___ What were the results?

5. When was your most recent MRI? ___/___/20___ What were the results?

6. What type of problems are you experiencing now?

7. My pain/problem is slowly getting… worse better staying the same

8. My pain bothers me constantly most of the time only occasionally once in a while

9. On a scale from 1 to 10, what is the worst your pain/problem has been in past several days?

Mild medium severe

1----------5----------10

10. Do you have any regular numbness or tingling? Yes No

11. What seems to make your pain worse?

a. When it does get worse, how long does it take before calming back down? _____

12. What do you do to make it feel better?

13. List any medications you are currently taking?

14. List all medical conditions you have, or were told you have?

_____ _____ ___/___/20___

Patient Name Signature Today's Date