Please fill in any of the below treatments you have undergone for your current symptoms/injury.

PHYSICAL THERAPY:

Clinic: ______________________________

Address: ______________________________

Phone:______________________________ Fax:______________________________

Approximate dates of treatment: ______________________________

PAIN MANAGEMENT:

Pain Management Doctor: ______________________________

Clinic: ______________________________

Address: ______________________________

Phone:______________________________ Fax:______________________________

Approximate dates of treatment: ______________________________

EMG/NCV (NERVE CONDUCTION TEST)

Facility it was completed at:

______________________________ phone______________________________

Physician who ordered:

______________________________ phone: ______________________________

Date completed:

____