Patient Name: **Date:**

Please check one of the boxes for each type of conservative therapy listed below. If you check either "Yes" or "No" for effectiveness, then please also enter a month and year that you started the therapy and either enter "current" or a month and year (i.e., 02/17-present, 02/17-10/17, etc.) in which the therapy ended.

Type of Therapy	Effective? Yes	Effective? No	Not Applicable (NA)	Duration (Mo/Yr-Mo/Yr)	Additional Details
Acupuncture					
Chiropractic Therapy					
Physical Therapy					
Traction					
Ice/Heat Therapy					
Behavioral Therapy					
Guided Imagery/Meditation					
Weight Loss/Nutrition Therapy					
Braces or Orthotics					
Electrical Stimulators					
TENS Unit					
Non-Invasive Decompression					
Spinal Injections					
Trigger Point Injections					
Stem Cell Injections					
LIST ALL SPECIFIC MEDICATIONS TAKEN IN ADDITIONAL DETAILS COLUMN:					
NSAIDS (Advil, Ibuprofen, Naproxen, etc.)					
Tylenol (Acetaminophen)					
Narcotic Medications (Vicodin, Norco, Percocet, Tramadol, etc.)					
Muscle Relaxer Medications (Flexeril, Soma, Baclofen, etc.)					
Nerve Pain Medications (Lyrica, Gabapentin, etc.)					
Antidepressant Medications (Effexor, Lexapro, Paxil, etc.)					
Anti Anxiety Medications (Ativan, Valium, Xanax, etc.)					
Medications - Other - Please list					
Other Unlisted Therapies - Please list					