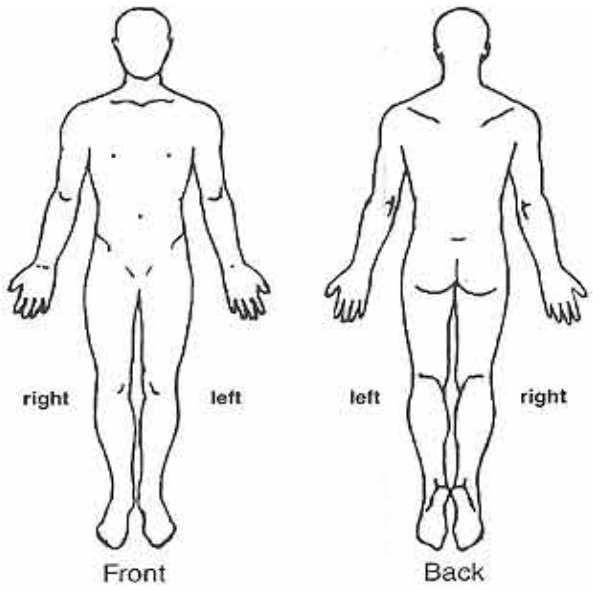
Patient Name _____ **Date** _____

1. **Describe your Symptoms** _____
   _____
   a. When did your symptoms start? _____
   b. How did your symptoms begin? _____

2. **How often do you experience your symptoms?**
   a. Constantly ◯ (76 - 100% of the day)
   b. Frequently ◯ (51 - 75% of the day)
   c. Occasionally ◯ (26 - 50% of the day)
   d. Intermittently ◯ (0 -25% of the day)

3. **What describes the nature of you symptoms?**
   a. Sharp ◯ d. Shooting ◯
   b. Dull Ache ◯ e. Burning ◯
   c. Numb ◯ f. Tingling ◯

4. **How are your symptoms changing?**
   a. Getting Better ◯
   b. Not Changing ◯
   c. Getting Worse ◯



Show Us Where It Hurts

5. **During the past four weeks:**
   a. On a scale of 0 to 10 (zero being none and 10 being unbearable) how would you rate your pain: Right now _____ At its best _____ At its worst _____
   b. How much of the time has your condition interfered with your social activities? (visiting with friends and relatives, etc.)
   ◯ All of the time ◯ Most of the time ◯ Sometimes ◯ A little of the time ◯ None
   c. How much has pain interfered with your normal work (including both work inside and outside the home)
   ◯ None ◯ Mildly ◯ Moderately ◯ Extremely

6. **Who have you seen for your symptoms?**
   ◯ No one ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other _____
   What treatment, if any, did you receive and when**?** _____
   _____

7. **What tests have you had for your symptoms and when were they performed?**
   a. X-rays (date): _____ c. CT Scan (date) _____
   b. MRI (date): _____ d. Other (date) _____

8. **Have you had similar symptoms in the past?** Yes ◯ No ◯
   a. If you have received treatment in the past for the same or similar symptoms, who did you see? _____