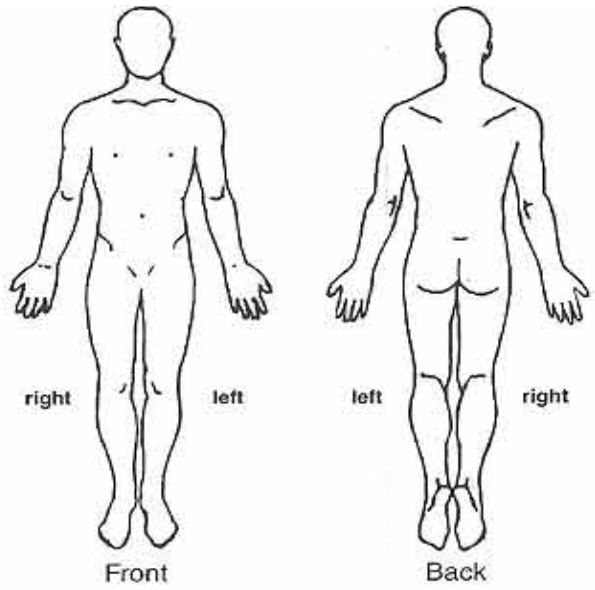
Patient Name _____ **Date** _____

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
   b. Dull Ache
   c. Numb
   d. Shooting
   e. Burning
   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.)
      a. All of the time b. Most of the time c. Sometimes d. A little of the time e. None
   c. How much has pain interfered with your normal work (including both work inside and outside the home)
      a. None b. Mildly c. Moderately d. Extremely

6. **Who have you seen for your symptoms?**
   a. No one b. Chiropractor c. Medical Doctor d. Physical Therapist e. 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): _____
   b. MRI (date): _____
   c. CT Scan (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? _____