

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?

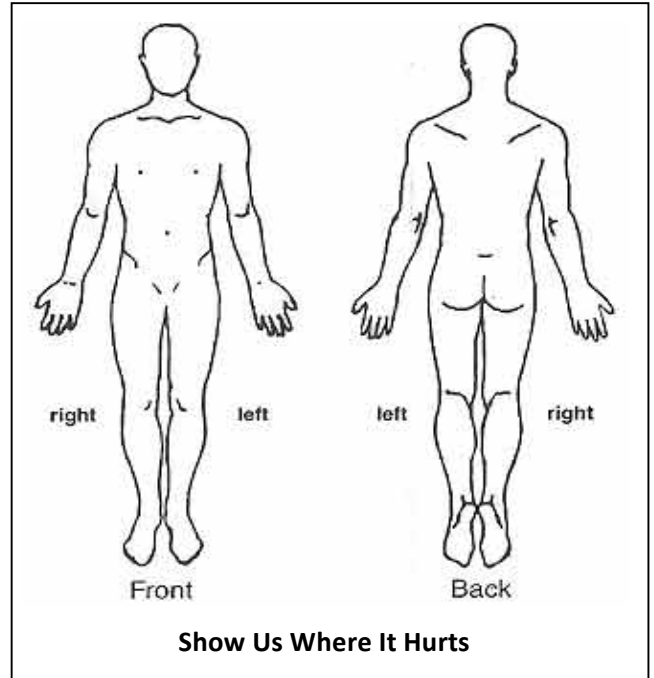
- a. Constantly (76 - 100% of the day)
- b. Frequently (51 - 75% of the day)
- c. Occasionally (26 - 50% of the day)
- d. Intermittently (0 - 25% of the day)

3. What describes the nature of your 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



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? _____