SYMPTOM QUESTIONAIRRE

PATIENT NAME_____DATE_____

WHERE ARE YOU HAVING YOUR MAJOR PROBLEMS? HEAD NECK LOW BACK SHOULDER BETWEEN SHOULDER BLADES HIP OTHER:

HOW LONG HAS THIS CONDITION LASTED?_____

IS THIS CONDITION: GETTING WORSE THE SAME IMPROVING

BRIEFLY DESCRIBE INITIAL CAUSE OF CONDITION (INJURY, ACCIDENT, ETC.):_____

_____

_____

PAIN CAME ON: GRADUALLY SUDDENLY

THE PAIN IS: OCCASIONAL FREQUENT CONSTANT

DESCRIBE THE PAIN: SHARP (LIKE A KNIFE) DULL (LIKE A TOOTHACHE BURNING (HOT)

DOES THE PAIN: STAY IN ONE SPOT RADIATE (TRAVEL OR SHOOT) GO UP OR DOWN THE SPINE

WHAT TIME OF DAY IS PAIN THE WORST? MORNING AFTERNOON EVENING NIGHT ALL THE TIME

DO YOU HAVE PAIN IN: LEGS FEET ARMS HANDS LEFT RIGHT OTHER:

DO YOU HAVE NUMBNESS, TINGLING OR PINS AND NEEDLES IN: LEGS FEET ARMS HANDS LEFT RIGHT OTHER:

WHAT MAKES THE PAIN WORSE?_____

WHAT MAKES THE PAIN BETTER?_____

DOES THE PAIN AFFECT YOUR SLEEPING? NO OCCASIONALLY FREQUENTLY CONSTANTLY

DOES PAIN AFFECT YOUR WORK? NO OCCASIONALLY FREQUENTLY CONSTANTLY

SUMMARY (DOCTOR'S USE)