SYMPTOM / PAIN INFORMATION

Name: _____ Today's Date: _____ Patient ID #: _____

Please describe the health problem for which you came to our office: _____

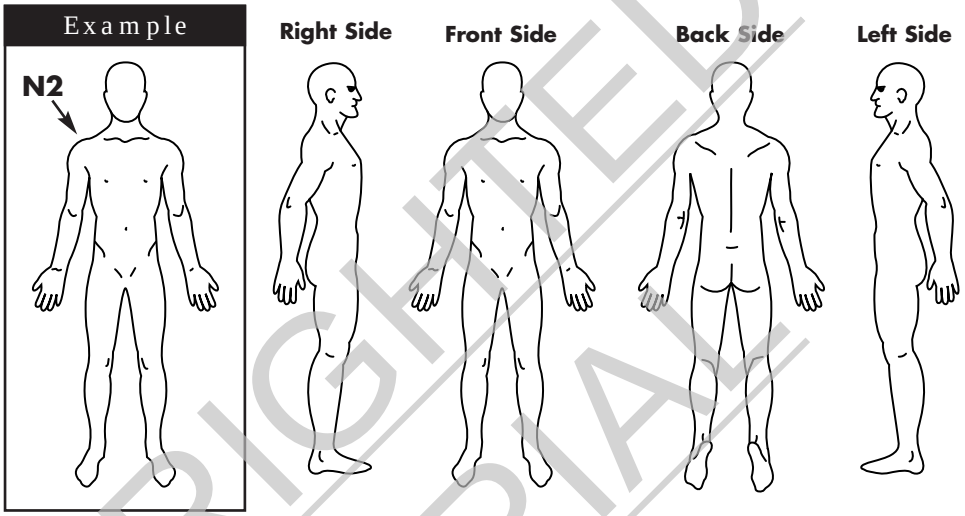
What type of physical activity or posture does your job involve? (prolonged sitting, standing, bending, etc.) _____

Please describe the character of your symptom(s). Some words often used include burning, tingling, aching, tired, numb, sharp, dull, stabbing, shooting, radiating, etc

_____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness . . . . . **N**
Pins & Needles . . . . . **P**
Burning . . . . . **B**
Aching . . . . . **A**
Stabbing . . . . . **S**



How long have you had this episode of symptoms? _____

How many times have you had a problem similar to or the same as this in the past? _____

When was the first time you ever felt something similar to or the same as your current problem? _____

Did symptoms begin? ❑ Gradually ❑ Suddenly Since your symptoms began, have they: ❑ Improved ❑ Worsened ❑ Same Are your symptoms constant? ❑ Yes ❑ No

Are there any times or positions when you do not experience your pain/discomfort (e.g. after exercising, while sleeping)? ❑ Yes ❑ No

If yes, please explain: _____

What caused your symptom(s) to occur (physical overuse, mental stress, accident, etc.)? _____

What aggravates your current symptoms? _____

Is your sleep disturbed by these symptoms? ❑ Yes ❑ No Do you sleep on a: ❑ Mattress ❑ Waterbed ❑ Futon ❑ Other _____

What is your normal sleeping position? ❑ Back ❑ Stomach ❑ Side ❑ Other _____

Are you restricted/limited in any work, home, or recreational activities because of your discomfort? ❑ Yes ❑ No

If yes, please explain: _____

Are your symptoms the result of an auto accident, work injury, or other personal injury? ❑ Yes ❑ No

Have you done anything to try and help or relieve your complaint such as: rest, heat, cold, aspirin, medications, sitting, lying down, etc? ❑ Yes ❑ No

If yes, please explain: _____

Are you now doing corrective exercises for your present symptoms? ❑ Yes ❑ No

If yes, briefly describe the exercises/stretches you are doing and who recommended them: _____

Do you participate in other exercises (aerobics, walking, jogging, etc.)? ❑ Yes ❑ No

If yes, please explain what type and how many times per week/month: _____

Have you seen a chiropractor outside of this office for this problem? ❑ Yes ❑ No If yes, whom did you see and when: _____

Were x-rays taken? ❑ Yes ❑ No What type of treatment was done? _____

On a scale of 1 (no improvement) to 10 (full improvement). How much did the treatment help? _____

Have you seen a physical therapist for this problem? ❑ Yes ❑ No If yes, whom did you see and when: _____

Were x-rays taken? ❑ Yes ❑ No What type of treatment was done? _____

On a scale of 1 (no improvement) to 10 (full improvement). How much did the treatment help? _____

Have you seen a chiropractor, physical therapist or osteopath for any other problem? ❑ Yes ❑ No

If yes, please explain: _____

Are you aware of any blood relatives with similar discomforts/problems? ❑ Yes ❑ No

If yes, please explain: _____

