SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Where are you having your major problems?

( ) Head ( ) Neck ( ) Shoulder ( ) Mid Back ( ) Lower Back ( ) Hip ( ) Other: _____

How long has this condition lasted? _____

Is this condition: ( ) Getting Worse ( ) The Same ( ) Improving ( ) Other: _____

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 sticking you) ( ) Dull (like a toothache) ( ) Burning (hot) ( ) Throbbing (pounding)

Does the pain: ( ) Stay in one spot ( ) Radiate (travel or shoot) ( ) Go up or down the spine

What time of day is your 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 sleep? ( ) No ( ) Occasionally ( ) Frequently ( ) Constantly

Does the pain affect your activities? ( ) No ( ) Occasionally ( ) Frequently ( ) Constantly

What activities are restricted? _____

Have you seen other doctors for this condition? ( ) No ( ) Yes - If yes, doctor's name: _____

Have you ever seen a chiropractor before? ( ) No ( ) Yes - If yes, doctor's name: _____

List major illnesses: _____

List major surgeries: _____

Please indicate your CURRENT pain level on the chart below: