

Patient Name: _____

Date: _____

What is your major symptom? _____

When was the first time you noticed this problem? _____

How did it originally occur? _____

Rate the pain on a scale of 1 - 10 (10 worst) : _____ Does the pain radiate? No ___ Yes _____

Do you experience numbness or tingling? _____

Describe the pain: Sharp _____ Stabbing _____ Burning _____ Dull _____ Aching _____ Sore _____ Stiff _____ Spasm _____
_____ Throbbing _____ Pins & Needles _____ Other _____

Has it become worse recently? Same _____ Better _____ Worse _____

How frequent is the condition? Constant _____ Intermittent _____

How long does it last? _____

Is there anything you can do to relieve the problem? If Yes, describe: _____

_____. If no, what have you tried to do that has not helped? _____

What makes the problem worse? Stand ___ Walk ___ Sit ___ Lying ___ Bend ___ Lift ___ Twist ___ Getting up & down ___
Cough ___ Other: _____

Are there any other conditions or symptoms that may be related to your major symptom? No ___ If Yes, describe: _____

Are there other unrelated health problems? No ___ If Yes, describe: _____

Have you had any broken bones? No ___ If Yes, please list and give dates: _____

List any other major accidents or injuries, either in the past or the present, not already described: _____

Have you had any major disease or illness, either in the past or the present, not already described? No ___ Yes _____

WOMEN Only: Is there any possibility you may be pregnant? Yes ___ No ___

Remarks: _____

