Symptom Questionnaire

Patient's Name: _____ Date: _____

I am here today for: __ Preventative Health Care __ Pain that has intensified __ An Injury
What is your present condition?

When did you first notice this condition?

If you have had this complaint before, when was the last episode intensified?

What caused the problem to occur?

Does the pain radiate to the:
__ Buttocks __ Legs __ Shoulders/Arms __ Hands __ Does NOT Radiate

Describe the pain:
__ Constant __ Intermittent __ Episodic __ Sharp __ Dull __ Achy __ Deep __ Stiff
__ Other _____

Can you perform all daily activities (work and home)? __ Yes __ No
If No, explain

What intensifies the pain?

Have you tried to relieve this problem at home? __ Yes __ No If Yes, describe the medication and/or treatment.

Have you had any x-rays since the onset of this condition? __ Yes __ No If Yes, When?_____
Where? _____ Phone: _____

Have you had any changes in weight or activity level in the past six months? __ Yes __ No

Have you had any bowel or bladder function changes? __ Yes __ No
__Constipation __ Frequency __ Urgency __ Pain __ Incontinence
__ Color changes __ Diarrhea __ Blood in urine/stools

Have you been treated by another physician for this problem? __ Yes __ No If Yes, who was the physician and when was the condition treated?

List all dates and a brief description for the following: *(Very Important)*

Automobile Accidents:_____

_____

Fractures: _____

Injuries: _____

Surgeries: _____

_____

Medications: _____

Please turn page over to answer questions on back

Neurological and Vascular Questionnaire

Have you had any of the following symptoms within the last year?

Y N

___ ___ Blurred vision or any visual disturbances? If yes, describe. _____

___ ___ Ringing, buzzing or any noise in the ears? _____

___ ___ Hearing loss in one or both ears? _____

___ ___ Slurred speech or other speech problems? _____

___ ___ Difficulty swallowing?_____

___ ___ Dizziness? _____

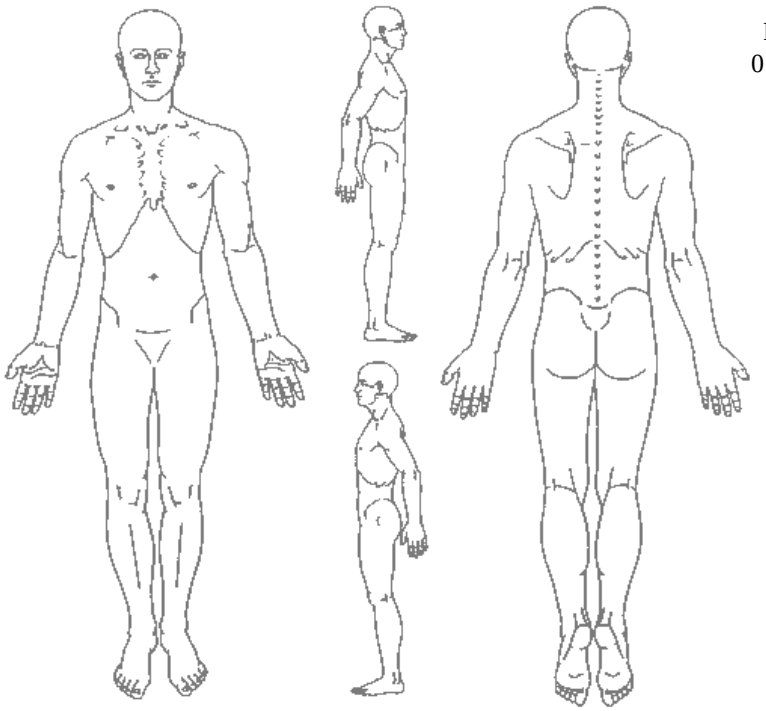
___ ___ Temporary loss of understanding? _____

___ ___ Loss of consciousness, even momentary blackouts? _____

___ ___ Numbness or loss of sensation in the face, arms, hands, fingers, legs or any other part of the body? _____

___ ___ Weakness or clumsiness in the face, arms, hands, fingers, legs or any other part of the body? _____

___ ___ Sudden collapse without loss of consciousness? _____



Pain Scale

Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Place an "X" on the drawing to the left on areas causing you pain and a letter describing it.

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & needles