

# Symptom Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1) Date Problem Began: \_\_\_\_\_

2) How did your current problem(s) begin:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Are there any positions or activities that make your symptoms worse? Yes No

(Describe) \_\_\_\_\_

4) Have you found anything that seems to relieve your symptoms? Yes No

(Describe) \_\_\_\_\_

5) Have you had spine x-rays, MRI or CT Scan? Yes NO

Date(s) taken: \_\_\_\_\_ What areas were taken? \_\_\_\_\_

Please complete the following questions for each problem that you are having

**Problem #1** \_\_\_\_\_

Problem 1 (How you feel today): Please Mark an " | " at your current level of symptoms

No pain or discomfort | \_\_\_\_\_ | Severe pain or discomfort

Since this problem began, are the symptoms: Increasing, Decreasing, Unchanged

How often are your symptoms present?

Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

**Problem #2** \_\_\_\_\_

Problem 2 (How you feel today): Please Mark an " | " at your current level of symptoms

No pain or discomfort | \_\_\_\_\_ | Severe pain or discomfort

Since this problem began, are the symptoms: Increasing, Decreasing, Unchanged

How often are your symptoms present?

Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

**Problem #3** \_\_\_\_\_

Problem 3 (How you feel today): Please Mark an " | " at your current level of symptoms

No pain or discomfort | \_\_\_\_\_ | Severe pain or discomfort

Since this problem began, are the symptoms: Increasing, Decreasing, Unchanged

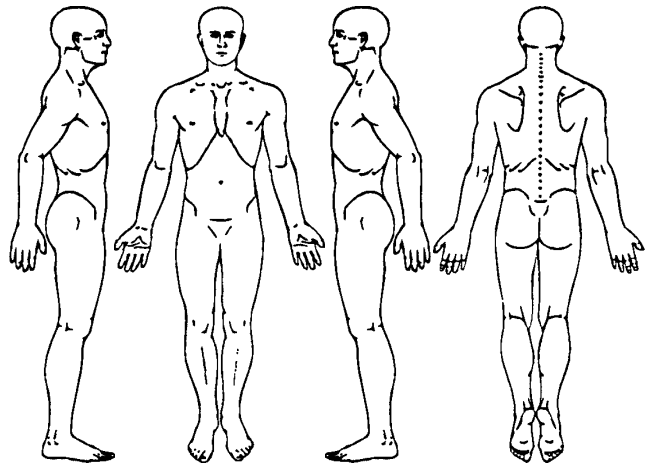
How often are your symptoms present?

Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)



Name: \_\_\_\_\_

On the diagrams, mark where you currently have pain or other symptoms. Include symptoms of pain, numbness, tingling, etc..



Please check all of the following that apply to you:  None Apply

- | Yes                      | No                       | Condition                            |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection          |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                         |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use (Steroid inhaler) |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills                  |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks           |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma                        |

- | Yes                      | No                       | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use: # _____ day/wk                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use: # _____ day/wk                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |
|                          |                          | _____   |
|                          |                          | _____   |
|                          |                          | _____   |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems / Stroke

Current Work Activities: Sit more than stand—Stand more than sit—Sit/stand equally—Walking

Previous Auto Injuries: None—Yes, describe \_\_\_\_\_

Previous Work Injuries: None—Yes, describe \_\_\_\_\_

Allergies: \_\_\_\_\_

Exercise Habits: None—Regular Program—Semi-regular program (Describe) \_\_\_\_\_

I certify that the above information is complete and accurate. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctors' Notes _____
_____
_____
_____
Initials _____