

Symptom Questionnaire

Name: _____ Date: _____

1) Date Problem Began: _____

2) Describe your current problem(s) and how it/they began:

1) How often are your symptoms present?

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

3) Can you perform your daily activities? Yes NO (Describe) _____

4) 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

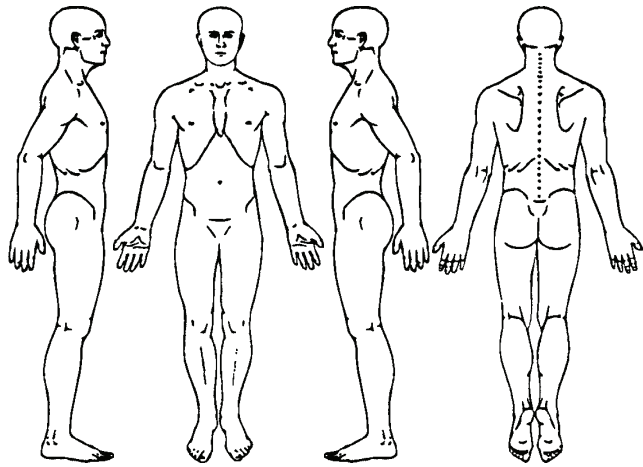
How often are your symptoms present?

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 _____