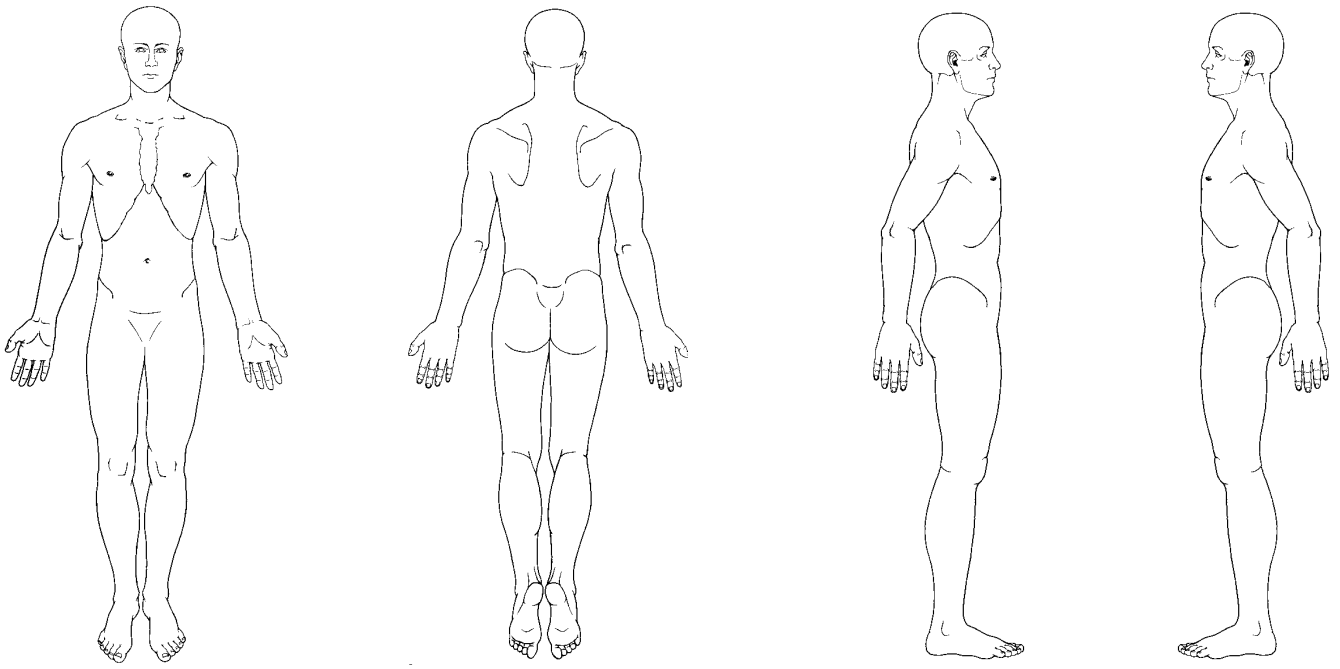
CHIEF CONCERN # ___ Date _____ Name _____

Specific Concern: _____ **Instructions:** *Use drawings to indicate areas of physical symptoms like pain, discomfort, limitations, etc.* Use one of these sheets for each of your main concerns. *If all your various concerns began at the same time and behave in the same way, you can put them all on a single form. For auto injuries, include all symptoms caused or worsened by the accident.*



Onset

When did you first notice this?

It came on: *Suddenly Gradually*

What were you doing at the time, or what do you think caused it? If injury, describe specifically how it happened, where the impact was, etc.

Since onset, overall it has gotten: *Better Worse Stayed the same Gone up & down Other*

Symptom Characteristics

Describe what it feels like: _____

Grade: How would you rate the **intensity** on this scale? *Draw an **oval** to depict the range from best to worst, and place an "X" where it is most of the time: Nothing (0)* | - - - - - - - - - - | *Severe (10)*

How often do you feel this? *(Use an X) Not at all* | - - - - - - - - - - | *Constant*

List any time of day, season, or other cycle when it's worse:

List any timing when it's better:

Radiation: Does the sensation seem to spread out, or "travel" to another area? *Yes No*

(If Yes, indicate this on the drawing above with an arrow, showing where it starts, and where it spreads to)

List anything you do that makes it better:

List anything you do that makes it worse:

Does it feel better when you lie down & rest? *Yes No* Does it affect your sleep? *Yes No*

If so, how?

Does this problem limit any of your regular activities? *Yes No* If so, please describe:

Chief Concern # ___ _____ Date _____ Name _____

Other Treatment

Other Practitioners you have seen for this problem:

Name _____ Name _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Month & year seen _____ Month & year seen _____

Diagnosis _____ Diagnosis _____

X-rays? *Y N* Areas? _____ X-rays? *Y N* Areas? _____

Urine or Blood tests? _____ Urine or Blood tests? *Y N*

Treatment received _____ Treatment received _____

Results _____ Results _____

What have you done for yourself to treat this?

1.
2.
3.

Outcomes (results of self treatment):

1.
2.
3.

Previous Problems

Have you had similar symptoms in the past? *Yes No* If yes, please give approximate timing and describe circumstance or relation to major events (e.g. mo/year it occurred, shortly after my divorce, etc):

Have you had any injuries to this area in the past? *Yes No* If yes, please describe circumstance and give approximate date:

Associated Symptoms

1) Do you experience any of the following? *Yes No* If yes, please circle relevant items:
   dizziness nausea vomiting loss of balance ringing in your ears difficulty swallowing vision changes forgetfulness temporary loss of consciousness or awareness

2) Do you experience any of the following? *Yes No* If yes, please circle relevant items:
   difficulty breathing shortness of breath coughing blood increased pain with exertion digestive trouble

3) Do you experience any of the following? *Yes No* If yes, please circle:
   Urinary: Increase or decrease in frequency *or* amount *of urination Pain with urination*
   Difficulty in starting urination Blood in urine (pink color)
   Bowel: Increase or decrease in frequency or ease of bowel mvmt Blood in stool
   Change in color, size or diameter of stools Pain with bowel mvmt

Family History of Similar Problem (similar to your chosen "concern" for this questionnaire)

Have others in your immediate family had similar health problems? *Yes No* If yes, please describe: