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:
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?  Outcomes (results of self treatment):
1. 1.
2. 2.
3. 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: