

1. What is your major symptom? _____
2. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
3. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
4. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No _____. If yes, describe _____
Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____
5. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
6. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____
7. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
8. Have you had any broken bones? Yes ___ No _____. If yes, please list and give dates _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ___ No _____. If yes, please explain _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain ___
12. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.