

**SYMPTOM QUESTIONNAIRE**

PATIENT NAME: \_\_\_\_\_

1. Is your visit to this clinic in reference to an accident? No Yes  
If yes, was it: Work Comp Automobile Slip/Fall Other

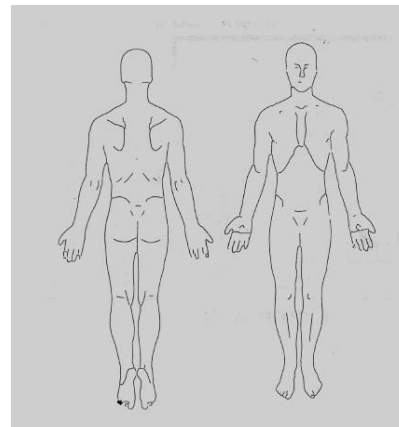
2. Mark on the model where you are having; P = pain A = aching  
T = tingling N = numbness

3. Please describe your complaints: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. When did this condition start? \_\_\_\_\_

5. Is this condition : Getting Worse The Same  
Improving Other

6. Briefly describe initial cause of condition (*injury, accident, etc*):  
\_\_\_\_\_  
\_\_\_\_\_



7. Describe any falls, surgery, and/or accidents in the past that may have contributed to your condition: \_\_\_\_\_  
\_\_\_\_\_

8. Pain came on : Gradually Suddenly

9. The pain is: Occasional Frequent Constant

10. Describe the pain: Sharp (*like a knife sticking in you*) Dull (*like a toothache*) Burning (*hot*)

11. Does the pain: Stay in one spot Radiate (*travel or shoot*) Go up or down the spine

12. What time of the day is pain the worst? Morning Afternoon Night At any time

13. Do you have pain in: Legs Feet Arms Hands Left Right Other

14. Do you have numbness, tingling or pins and needles in: Legs Feet Arms Hands Left Right Other

15. What makes the pain worse? \_\_\_\_\_

16. What makes the pain better? \_\_\_\_\_

17. Does the pain affect your sleeping? No Occasionally Frequently Constantly

18. Does the pain affect your work? No Occasionally Frequently Constantly

19. Have you seen other doctors for this condition? No Yes If yes, doctor's name \_\_\_\_\_

20. Have you seen a chiropractor before? No Yes If yes, doctor's name \_\_\_\_\_

21. Have you missed work? No Yes If yes, how long were you off work? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

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