SYMPTOM QUESTIONNAIRE

This information will help us determine if conservative care will benefit you. Please print and be as accurate and complete as possible. The doctor will go over the questions with you when completed.

Patient Name: Date:

Is your visit to this clinic in reference to an accident? ☐ Yes ☐ No
If yes, was it: ☐ Work Comp ☐ Automobile ☐ Personal Injury ☐ Other

Where are you having your major problems? ☐ Head ☐ Neck ☐ Lower Back ☐ Shoulder ☐ Between Shoulder Blades ☐ Hip ☐ Other:

Please describe your complaints fully:

How long has this condition lasted?

Is this condition: ☐ Getting Worse ☐ The Same ☐ Improving ☐ Other:

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

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

Pain came on: ☐ Gradually ☐ Suddenly The pain is: ☐ Occasional ☐ Frequent ☐ Constant

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

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

What time of day is pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ At the time

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

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

What makes the pain worse? What makes the pain better?

Does the pain affect your sleeping: ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly
Does pain affect your work? ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes If yes, for what?

Have you had major surgery in the last 5 years? ☐ No ☐ Yes If yes, what surgery?

Have you seen other doctors for this condition? ☐ No ☐ Yes If yes, doctor's name:

Have you ever seen a chiropractor before? ☐ No ☐ Yes If yes, doctor's name

Are you taking medication(s)? ☐ No ☐ Yes If yes, for what:

Are you pregnant? ☐ No ☐ Yes

Have you missed work? ☐ No ☐ Yes If yes, how long were you off work?

Patient's Signature: Date:

(*if a minor, parent's or guardian's signature*)

SX? 1/98 **BLUE**

NAME (Please Print): ______________________________ DATE: ______________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ______________________

USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW
(Please remember to complete both sides of this form.)

KEY:	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER