

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.

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_