Patient Name: _____ Visit Date _____/ _____/ _____

My worst symptom is:

- ☐ Pain
- ☐ Numbness, tingling or loss of sensation
- ☐ Weakness
- ☐ Other: _____

PAIN

Numbness Tingling or Loss of Sensation

Weakness

Other

Patient Name: _____ Visit Date _____/ _____/ _____

ONSET

When did your symptoms start and what were you doing at the time?

_____

_____

_____

_____

Progression

Since your symptoms began, have they improved, worsened, or stayed the same?

_____

_____

_____

_____

What makes your symptoms worse?

_____

_____

_____

What interventions have you recently tried to improve your symptoms?

☐ Rest ☐ Ice / Heat ☐ Brace ☐ Over the counter pain medications ☐ Prescription pain medications

☐ Chiropractic therapy ☐ Massage therapy ☐ Injections ☐ Physical therapy ___ wks/6mos

_____

_____

_____

What makes your symptoms better?

_____

_____

_____

Lifestyle

What areas of your life are significantly impacted by your <u>current</u> condition?

☐ Work ☐ Exercise & fitness ☐ Sleep ☐ Sex-life ☐ Weight gain ☐ Weight loss

☐ Household chores ☐ Enjoyable activities ☐ Mental well-being ☐ Hygiene