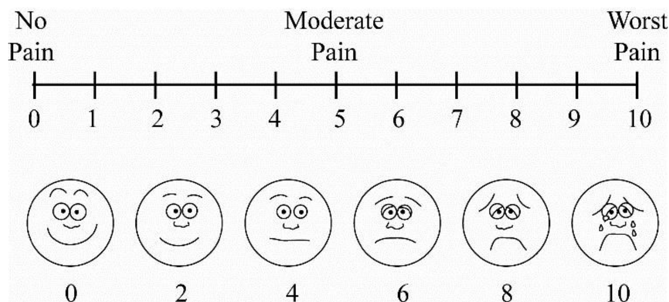
eagle cramer CHIROPRACTIC

# Patient Symptom Form

**Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc. Please let the front desk know if you need additional forms.*

**Patient Name** ______________________________ **Date** _________________

**Area of Symptom** _____________________________




- On a scale of 1-10, with 10 being the worst, **please circle** the number that best describes the symptom most of the time: ___________
- What percentage of the time you are awake do you experience the above symptom at the above intensity? 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin?
  .___________________________________________________________________
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?______________________________________
- What makes the symptom worse? (circle all that apply)
  - Bending neck forward, bending neck backward, tilting head to the left, tilting head to the right, turning head to the left, turning head to the right, bending forward at the waist, bending backward at the waist, tilting left at the waist, tilting right at the waist, twisting left at the waist, twisting right at the waist, stooping, sitting, standing, getting up from sitting position, sleeping, lifting, any movement, walking, running, typing, lifting arm, nothing, other (please describe):

    ___________________________________________________________________
- What makes the symptom better? (circle all that apply)
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, lying down, nothing, other (please describe):

    ___________________________________________________________________
- Describe the quality of the pain (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, tingling, numbness, other (please describe):

    ___________________________________________________________________
- Does the symptom radiate to another part of your body? (circle one) yes no
  - If yes, where does the symptom radiate?________________________________
- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

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