Name_____

NEW PATIENT CURRENT SYMPTOM FORM

(Please start at the top of your body, and work your way down- i.e. Headache, Neck pain, etc….)

Symptom 1: _____

- ***On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptoms most of the time:***
  1 2 3 4 5 6 7 8 9 10

- ***Circle which best describe your pain:*** aching burning cramping deep diffuse dull numbness radiating sharp shooting stiffness tight tingling

- ***Which best describes your pain frequency:*** constant frequent intermittent occasional

- ***Pain is radiating?*** Y / N **If Yes, Then where is it radiating?** (circle those that apply):
  LEFT: arm hand shoulder leg foot neck head jaw
  RIGHT: arm hand shoulder leg foot neck head jaw

- ***Pain is Better:*** afternoon morning evening
- ***Pain is Worse:*** afternoon morning evening unchanged throughout day

- ***Pain is Aggravated by:*** overhead activities reaching sitting standing preparing food resting sneezing twisting walking bending coughing driving exercising getting up and down housework lifting lying down

- ***Pain is Relieved by:*** exercise ibuprofen knees bent up lying down no movement heat ice lifting medication reaching resting standing walking sitting stretching no movement

- ***Other things you have tried:*** acupuncture over the counter meds prescription meds surgery chiropractic massage

- ***Anything else I should know about your condition?*** _____

Symptom 2: _____

- ***On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptoms most of the time:***
  1 2 3 4 5 6 7 8 9 10

- ***Circle which best describe your pain:*** aching burning cramping deep diffuse dull numbness radiating sharp shooting stiffness tight tingling

- ***Which best describes your pain frequency:*** constant frequent intermittent occasional

- ***Is pain radiating?*** Y / N If Yes , Then to (circle those that apply):
  LEFT: arm hand shoulder leg foot neck head jaw
  RIGHT: arm hand shoulder leg foot neck head jaw

- ***Pain is Better:*** afternoon morning evening
- ***Pain is Worse:*** afternoon morning evening unchanged throughout day

- ***Pain is Aggravated by:*** overhead activities reaching sitting standing preparing food resting sneezing twisting walking bending coughing driving exercising getting up and down housework lifting lying down

- ***Pain is Relieved by:*** exercise ibuprofen knees bent up lying down no movement heat ice lifting medication reaching resting standing walking sitting stretching no movement

- ***Other things you have tried:*** acupuncture over the counter meds prescription meds surgery chiropractic massage

- ***Anything else I should know about your condition?*** _____

Name_____

NEW PATIENT CURRENT SYMPTOM FORM

(Please start at the top of your body, and work your way down- i.e. Headache, Neck pain, etc….)

Symptom 3: _____

- ***On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptoms most of the time:***
  1 2 3 4 5 6 7 8 9 10

- ***Circle which best describe your pain:*** aching burning cramping deep diffuse dull numbness radiating sharp shooting stiffness tight tingling

- ***Which best describes your pain frequency:*** constant frequent intermittent occasional

- ***Pain is radiating?*** Y / N **If Yes, Then where is it radiating?** (circle those that apply):
  LEFT: arm hand shoulder leg foot neck head jaw
  RIGHT: arm hand shoulder leg foot neck head jaw

- ***Pain is Better:*** afternoon morning evening
- ***Pain is Worse:*** afternoon morning evening unchanged throughout day

- ***Pain is Aggravated by:*** overhead activities reaching sitting standing preparing food resting sneezing twisting walking bending coughing driving exercising getting up and down housework lifting lying down

- ***Pain is Relieved by:*** exercise ibuprofen knees bent up lying down no movement heat ice lifting medication reaching resting standing walking sitting stretching no movement

- ***Other things you have tried:*** acupuncture over the counter meds prescription meds surgery chiropractic massage

- ***Anything else I should know about your condition?*** _____

Symptom 4: _____

- ***On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptoms most of the time:***
  1 2 3 4 5 6 7 8 9 10

- ***Circle which best describe your pain:*** aching burning cramping deep diffuse dull numbness radiating sharp shooting stiffness tight tingling

- ***Which best describes your pain frequency:*** constant frequent intermittent occasional

- ***Is pain radiating?*** Y / N If Yes , Then to (circle those that apply):
  LEFT: arm hand shoulder leg foot neck head jaw
  RIGHT: arm hand shoulder leg foot neck head jaw

- ***Pain is Better:*** afternoon morning evening
- ***Pain is Worse:*** afternoon morning evening unchanged throughout day

- ***Pain is Aggravated by:*** overhead activities reaching sitting standing preparing food resting sneezing twisting walking bending coughing driving exercising getting up and down housework lifting lying down

- ***Pain is Relieved by:*** exercise ibuprofen knees bent up lying down no movement heat ice lifting medication reaching resting standing walking sitting stretching no movement

- ***Other things you have tried:*** acupuncture over the counter meds prescription meds surgery chiropractic massage

- ***Anything else I should know about your condition?*** _____