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NEW PATIENT SYMPTOM FORM

Patient Name: ______________________ *Date:* ______________________

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 your symptoms most of the time:

1 2 3 4 5 6 7 8 9 10

What percentage (%) of the time you are awake do you experience the above symptom at the intensity you indicated above:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- ***When*** did the symptom begin? ______________________
- Did the symptoms begin ***SUDDENLY or GRADUALLY*** ? (circle one)
- ***How*** did the symptom begin? ______________________

What makes the symptoms worse? (mark all that apply)

☐ Bending neck forward ☐ Bending neck backward ☐ Standing ☐ Any movement
☐ Bending forward at waist ☐ Bending backward at waist ☐ Lifting ☐ Nothing
☐ Tilting head left ☐ Tilting head right ☐ Sitting ☐ Getting up from sitting
☐ Turning head left ☐ Turning head right ☐ Driving ☐ Other:
☐ Tilting left at waist ☐ Tilting right at waist ☐ Walking
☐ Twisting left at waist ☐ Twisting right at waist ☐ Running

What makes the symptom feel better? (mark all that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of the symptom (mark all that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

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? (mark one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

SYMPTOM 2

On a scale from 0-10, with 10 being the worst, please circle the number that best describes your symptoms most of the time:

1 2 3 4 5 6 7 8 9 10

What percentage (%) of the time you are awake do you experience the above symptom at the intensity you indicated above:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- ***When*** did the symptom begin? ______________________________
- Did the symptoms begin ***SUDDENLY or GRADUALLY*** ? (circle one)
- ***How*** did the symptom begin? ______________________________

What makes the symptoms worse? (mark all that apply)

☐ Bending neck forward ☐ Bending neck backward ☐ Standing ☐ Any movement
☐ Bending forward at waist ☐ Bending backward at waist ☐ Lifting ☐ Nothing
☐ Tilting head left ☐ Tilting head right ☐ Sitting ☐ Getting up from sitting
☐ Turning head left ☐ Turning head right ☐ Driving ☐ Other:
☐ Tilting left at waist ☐ Tilting right at waist ☐ Walking
☐ Twisting left at waist ☐ Twisting right at waist ☐ Running

What makes the symptom feel better? (mark all that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of the symptom (mark all that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

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? (mark one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

SYMPTOM 3

On a scale from 0-10, with 10 being the worst, please circle the number that best describes your symptoms most of the time:

1 2 3 4 5 6 7 8 9 10

What percentage (%) of the time you are awake do you experience the above symptom at the intensity you indicated above:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- ***When*** did the symptom begin? ______________________________
- Did the symptoms begin ***SUDDENLY or GRADUALLY*** ? (circle one)
- ***How*** did the symptom begin? ______________________________

What makes the symptoms worse? (mark all that apply)

☐ Bending neck forward ☐ Bending neck backward ☐ Standing ☐ Any movement
☐ Bending forward at waist ☐ Bending backward at waist ☐ Lifting ☐ Nothing
☐ Tilting head left ☐ Tilting head right ☐ Sitting ☐ Getting up from sitting
☐ Turning head left ☐ Turning head right ☐ Driving ☐ Other:
☐ Tilting left at waist ☐ Tilting right at waist ☐ Walking
☐ Twisting left at waist ☐ Twisting right at waist ☐ Running

What makes the symptom feel better? (mark all that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of the symptom (mark all that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

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? (mark one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

SYMPTOM 4

On a scale from 0-10, with 10 being the worst, please circle the number that best describes your symptoms most of the time:

1 2 3 4 5 6 7 8 9 10

What percentage (%) of the time you are awake do you experience the above symptom at the intensity you indicated above:

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- ***When*** did the symptom begin? ______________________________
- Did the symptoms begin ***SUDDENLY or GRADUALLY*** ? (circle one)
- ***How*** did the symptom begin? ______________________________

What makes the symptoms worse? (mark all that apply)

☐ Bending neck forward ☐ Bending neck backward ☐ Standing ☐ Any movement
☐ Bending forward at waist ☐ Bending backward at waist ☐ Lifting ☐ Nothing
☐ Tilting head left ☐ Tilting head right ☐ Sitting ☐ Getting up from sitting
☐ Turning head left ☐ Turning head right ☐ Driving ☐ Other:
☐ Tilting left at waist ☐ Tilting right at waist ☐ Walking
☐ Twisting left at waist ☐ Twisting right at waist ☐ Running

What makes the symptom feel better? (mark all that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of the symptom (mark all that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

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? (mark one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day