Patient Symptom Form

Patient Name ______________________ Date ______________

SYMPTOM ______________________________

What level would you rate your pain MOST OF THE TIME? None = 0 10 = Most Severe

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

What percentage of the time YOU ARE AWAKE do yo experience your symptoms at the above noted level of pain?

10%☐ 20%☐ 30%☐ 40%☐ 50%☐ 60%☐ 70%☐ 80%☐ 90%☐ 100%☐

Did your symptoms begin: ☐ Suddenly ☐ Gradually When did it begin ? ______________

How did your symptoms begin? ______________________________

Please mark the drawings below by using the appropriate symbols that match your complaints

If your symptom is:

Aching - use	XXXX
Burning	BBBB
Stabbing	^ ^ ^ ^
Numbness	NNNN
Pins/Needles	PPPP
Other	////

L R L

Over the past MONTH has your pain

☐ Improved ☐ Worsened ☐ Not Changed

Over the past WEEK has your pain ☐ Improved ☐ Worsened ☐ Not Changed

CHECK ANY/ALL THAT MAKE SYMPTOMS WORSE

☐ Nothing ☐ Any Movement ☐ Bending Neck Forward ☐ Bending Neck Backward

☐ Tilting Head to Left ☐ Tilting Head to Right ☐ Turning Head to Left ☐ Turning Head to Right ☐ Bending Forward at Waist

☐ Bending Backward at Waist ☐ Tilting Left at Waist ☐ Tilting Right at Waist ☐ Twisting Left at Waist ☐ Twisting Right at Waist

☐ Driving ☐ Standing ☐ Walking ☐ Running ☐ Lifting ☐ Sitting ☐ Getting Up From Seated Position ☐ Chewing

☐ Changing Positions ☐ Lying Down ☐ Reading ☐ Working ☐ Exercising ☐ Lying On Side In Bed ☐ Other:

WHAT MAKES SYMPTOMS BETTER ? ☐ Nothing ☐ Resting ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Walking

☐ Pain Medication ☐ Muscle Relaxers ☐ Chiropractic Adjustments ☐ Massage

☐ Other:______________________________

Quality of symptom: check all that apply ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep Nagging ☐ Shooting ☐ Stinging ☐ Other

Does the pain radiate (travel) Yes ☐ No ☐ If yes where does it radiate to? ______________________

Is the symptom worse at different times of day ?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No-same ☐ Other

What prior treatment have you tried for your condition?

☐ Anti-Inflammatory (NSAIDS) ☐ Pain Medication ☐ Muscle Relaxers ☐ Trigger Point Injections ☐ Cortisone Injection

☐ Massage ☐ Surgery ☐ Physical Therapy ☐ Other:

Procedure /Year/Results Procedure /Year/Results Procedure /Year/Results

What prior tests have been done for your condition?		PT GOALS: Tell me 4 activities of daily life that you can't do as well because of pain. And circle the ones you would most like to work towards restoring.
X-ray	Date	
MRI	Date	#1
CT	Date	#2
Lab Work	Date	#3
Other	Date	#4