

Tell Us About Your Problem

Name: _____ Today's Date: _____

1. What is your major complaint/symptom? _____

2. Does it radiate anywhere (arms or legs)? Yes No
If yes, please describe: _____

3. Date of first symptom/injury: _____ time of injury: _____ A.M. or P.M.

4. How did it originally occur? _____

5. Is it getting: ___ better ___ worse ___ staying the same

6. How frequent is the condition? ___ constant ___ comes and goes

7. Describe the pain: ___ sharp ___ dull ___ numb ___ tingling ___ aching
___ burning ___ stabbing ___ throbbing ___ other: _____

8. Are there any other symptoms or problems related to your major symptom? Yes No
If yes, please describe: _____

9. Is there anything you can do to relieve the problem? Yes No
If yes, please describe: _____

10. What makes the problem worse? ___ standing ___ sitting ___ lying ___ bending
___ lifting ___ twisting ___ other: _____

11. Have you ever had the same or similar condition in the past? Yes No
If yes, please describe and give dates: _____

12. Are you ___ right handed, ___ left handed, or ___ ambidextrous?

13. What is your occupation? _____
Does it involve heavy lifting (more than 25 lbs.)? Yes No
Do you sit at a desk or computer for long periods of time? Yes No

Signature: _____ Date: _____