

SYMPTONS

Name _____ Date _____

1. What is your major symptom? _____

2. If this is a reoccurrence, when was the first time you noticed this problem? _____

How did it occur? _____

Has it become worse recently? _____. If yes, when and how? _____

3. How frequent is the condition? _____

How long does it last? _____

4. Are there any other conditions or symptoms you have that may be related to your major symptom? _____

5. If pain is involved, what type is it-sharp, dull, etc.? _____

6. Is there anything you can do which seems to provide relief? _____

7. What things seem to make it worse? _____

8. Have you had any broken bones? _____. If yes please list them and give dates. _____

9. List any major accidents you have had other than those that might be mentioned above. _____

10. To your knowledge, have you had any diseases, major accidents, or injuries not indicated on this form either in the past or present? _____ If yes, please explain: _____

11. WOMEN ONLY: Are you pregnant or do you think you might be pregnant? Yes () No ()

12. Remarks: _____