SYMPTOMS

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: _____

_____