Symptom History Questionnaire

Patient's name: Date symptoms began:

Briefly describe your symptoms:

Are you staying the same or getting worse? (Circle one)

Were your symptoms bought on by a traumatic event? (Yes) (No)

How did your symptoms begin? (Circle one)

(1) Slowly over time
(2) Initial onset of pain (within the last 3 months)
(3) Recurrent onset of pain (one or more episodes within the last 3 months)
(4) Chronic (continuous duration of pain lasting longer then 3 months)

How often do you experience these symptoms? (Circle one)

(1) Constant 76-100% of the time
(2) Frequent 51-75% of the time
(3) Occasional 26-50 % of the time
(4)Intermittent 0-25% of the time

Did you go to the hospital or another doctor before coming here? (Yes) (No)
If yes, please provide the hospital, facility or doctor's name.

Have you ever had previous Chiropractic care? (Yes) (No)

What is you occupation?

Have you missed any time from work due to your current symptoms? (Yes) (No)
If yes, please list hours or days missed due to your incapacity.

Where do you work?