SPINAL SOLUTIONS

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PATIENT SYMPTOM SHEET –

Patient Name: _____ **DOB:** _____ **Date:**_____

What is your number one problem or **one area** of greatest pain?	
When did this problem/pain start?	☐ Gradual ☐ Progressive ☐ Sudden
What do you think caused this problem?	
What **increases** your pain?	
What **decreases** your pain?	
Describe your pain: (examples: Dull, ache, sharp, burning, tingling, numb, weakness, cramping stretch, tight, pulling, sore, hot, cold, etc...)	
Does your pain travel, spread, radiate? (Example: down your arm or leg?)	
Please rate your pain on a scale of 1 – 10 with 1 being the least amount of pain and 10 being the worst. 0 would mean no pain now.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
How often do you experience this pain?	____ times per ☐ hour ☐ day ☐ week **AND/OR** ☐ 1-2 hrs. per day ☐ ½ the day ☐ Most of the day ☐ Pain never leaves
Have you ever had this pain before?	
Have you ever been involved in a Motor Vehicle accident or injured on the job?	
Are you pregnant?	
Have you ever seen a Doctor, Chiropractor, Physical Therapist or anyone else for this pain?	