

SYMPTOM SURVEY

NAME _____

DATE _____

GENERAL SYMPTOMS (check as many as apply)

<input type="checkbox"/> nervousness	<input type="checkbox"/> irritability	<input type="checkbox"/> fatigue	<input type="checkbox"/> depression
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> tension	<input type="checkbox"/> PMS	<input type="checkbox"/> jaw pain

HEADACHE (check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
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How often:

1	2	3	4	5	6	7	times per day, week, month
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Location:

<input type="checkbox"/> Back of head	<input type="checkbox"/> Forehead	<input type="checkbox"/> Temples
<input type="checkbox"/> Right side	<input type="checkbox"/> Left side	<input type="checkbox"/> Behind eyes

NECK (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
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Pain type:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Ache	<input type="checkbox"/> Burning
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Do you have:

<input type="checkbox"/> stiffness	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> grinding upon movement
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Movement:

<input type="checkbox"/> stiffness	<input type="checkbox"/> restricted movement	<input type="checkbox"/> pain upon movement
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SHOULDERS (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
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Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
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Do you have:

<input type="checkbox"/> stiffness	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> grinding upon movement
------------------------------------	--	---

Movement:

<input type="checkbox"/> stiffness	<input type="checkbox"/> restricted movement	<input type="checkbox"/> pain upon movement
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MIDBACK (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
------------------------------------	-------------------------------------	-------------------------------------

Pain type:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Ache	<input type="checkbox"/> Burning
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Movement:

<input type="checkbox"/> Stiffness	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Pain Upon Movement
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LOWBACK (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
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Pain type:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Ache	<input type="checkbox"/> Burning
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Movement:

<input type="checkbox"/> Stiffness	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Pain Upon Movement
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HIP (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
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Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
------------------------------------	-------------------------------------	-------------------------------------

Pain type:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Ache	<input type="checkbox"/> Burning
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Movement:

<input type="checkbox"/> Stiffness	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Pain Upon Movement
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CHEST (pain - check those that apply):

Deep chest pain:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
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Do you have:

<input type="checkbox"/> shortness of breath	<input type="checkbox"/> irregular heartbeat
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KNEE (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
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Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
------------------------------------	-------------------------------------	-------------------------------------

Pain type:

<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Ache	<input type="checkbox"/> Burning
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Movement:

<input type="checkbox"/> Stiffness	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Pain Upon Movement
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FOOT/ANKLE (pain - check those that apply):

<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
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How often:

<input type="checkbox"/> occasional	<input type="checkbox"/> intermittent	<input type="checkbox"/> frequent	<input type="checkbox"/> constant
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Pain Scale (1 no pain, 10 extreme pain):

1	2	3	4	5	6	7	8	9	10
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Location:

<input type="checkbox"/> left side	<input type="checkbox"/> right side	<input type="checkbox"/> both sides
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Do you have:

<input type="checkbox"/> stiffness	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> grinding upon movement
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Movement:

<input type="checkbox"/> stiffness	<input type="checkbox"/> restricted movement	<input type="checkbox"/> pain upon movement
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