Office Use

BP: _____/_____

Pulse: _____

Weight: _____

Height: _____

Patient Name: _____

Date: ___ ___ ___
MM DD YY

Info Update: Please check Y or N

☐Y	☐N	New Address
☐Y	☐N	New Insurance
☐Y	☐N	Have you hit your deductible?
☐Y	☐N	Medication changes
☐Y	☐N	Surgery/Injury since last visit

1. When or approximately when did it start? _____

2. Did it begin gradually or suddenly? _____

3. Did anything cause or contribute to the onset? No Yes _____

4. Have you ever had anything like this before? No Yes
   -If yes, did it feel the same? What was the outcome? _____

5. Can you point to the exact location of your symptoms? No Yes
   Describe _____

6. Does it travel (radiate) to any other part of your body? No Yes
   Describe _____

7. Do you have symptoms in any other part of your body? No Yes
   Describe _____

8. Can you describe the sensation? (Dull, sharp, burning, aching, gnawing, throbbing, shooting, constricting, other) _____

9. How would you describe the intensity?
   (Mild, moderate, severe, other; 1-10 scale)_____

10. Has it been constant or does it come & go?
    (Constant, intermittent, episodic) _____

11. Has it been getting better, worse, or staying the same? _____

12. Have you found anything that makes it better? (Rest, morning, evening, certain position, other)
No or Yes_____

13. Have you found anything that makes it worse? (Positions, activities, morning, evening, coughing, sneezing, straining, other) No or Yes _____

14. Has there been a change in bodily functions? (Urination, defecation, respiration, digestion, vision, sexual, other) No or Yes _____

15. Has it affected your daily activities in any way? No or Yes _____

16. Have you tried store bought or home remedies? No or Yes
-If yes, were they effective? _____

17. Have you sought other professional care for this condition? No or Yes _____

18. Is there anything else you would like to discuss or that would be important for me to know?
_____

N-Numbness P-Pins and needles B-Burning A-Aching S-Stabbing