# Patient Symptoms Report and Diagram

Name: ______________________________________________ DOB: _____/_____/_____

**Please circle the appropriate number below showing how bad your pain is now:**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Now:** | **No pain** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst possible pain** |
| **At Worst:** | **No pain** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst possible pain** |
| **At Best:** | **No pain** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst possible pain** |

1. **What is the purpose of Today's Evaluation?**

_______________________________________ _________________________________________________

2. **Are you still working?** □ **Yes** □ **No** if not when was the last day on the Job**?** __________________

3. **Occupation:**____________________________________________________________________________

4. **When (roughly what date) did your present pain start?** ________________

5. **How did symptoms start?** (Check appropriate box)

| | | | | |
|---|---|---|---|---|
| □ No apparent cause | □ Gradually | □ Twisting | □ Bending | |
| □ Lifting | □ Fall | □ Pulling /Pushing | □ Suddenly | |
| □ Injured during workDate:____/_____/______ | | □ Injured in auto accident Date:____/_____/______ | | □ Injured at sportsDate:____/_____/______ |

**6. Have you had similar pain in the past?** □ Yes □ No □ Date ____/_____/_____

**7. Have you been hospitalized for your pain problem?** □ Yes □ No Date ____/_____/____

**8. How do you describe your pain?** □ Constant □ Intermittent

**9. What describes the nature of your symptoms?**

| | | |
|---|---|---|
| □ **Sharp** | □ **Shooting** | □ **Burning** |
| □ **Dull ache** | □ **Numb** | □ **Tingling** |

**10. What activities make the pain?**

| | **Better** | **Worse** | **No Difference** | **Comments** |
|---|---|---|---|---|
| □ **Exercise** | | | | □**During**<br>□**After** |
| □ **Lying down** | | | | □ **supine** |

| | | | | □ right side □ left side |
|---|---|---|---|---|
| □ Sitting | | | | □How long |
| □ Standing | | | | □How long |
| □ Walking | | | | □Distance |
| □ Bending | | | | □forward / backward<br><br>□ right side □ left side |
| □ Overhead activities | | | | |
| □Lifting / pushing / pulling | | | | |
| □ Coughing/ Sneezing | | | | |
| □ Pain Medications | | | | |
| □ Other | | | | |

**11. What medications are you currently taking?**

**12. Have you received any of the following tests?** **Date:**

| □ Diagnostic x-rays | □CT(computedtomography) scan | □Electromyogram(EMG) |
|---|---|---|
| □Discogram | □ MRI(magnetic resonance imaging) | □ Others _____________ |

**13. In general would you say your overall health right now is…**

| □ Excellent | □ Very good | □ Good | □ Fair | □ Poor |
|---|---|---|---|---|

**14. Medical history** (Circle Yes or No)

| Allergies | Y / N | Currently Pregnant | Y / N | Kidney Problems | Y / N |
|---|---|---|---|---|---|
| Anemia | Y / N | Depression | Y / N | Metal Implants | Y / N |
| Anxiety | Y / N | Diabetes | Y / N | Multiple Sclerosis | Y / N |
| Arthritis | Y / N | Dizzy Spells | Y / N | Osteoporosis | Y / N |
| Asthma | Y / N | Emphysema/Bronchitis | Y / N | Parkinsons | Y / N |
| Cancer | Y / N | Fractures | Y / N | Rheumatoid Arthritis | Y / N |
| Cardiac Conditions | Y / N | Gallbladder problems | Y / N | Seizures | Y / N |
| Cardiac Pacemaker | Y / N | Hepatitis | Y / N | Speech Problems | Y / N |
| Chemical Dependency | Y / N | High Blood Pressure | Y / N | Strokes | Y / N |
| Circulation Problems | Y / N | Incontinence | Y / N | Thyroid Disease | Y / N |
| Tuberculosis | Y / N | Vision Problems | Y / N | Other: | |

**15. Fall History:**

□ Injury as a result of fall in the past year: Yes / No When: _______________.

□ Two or more falls in the past year: Yes / No When: _______________.

**16. Surgical History:** (If additional space needed use the back of this sheet) □ Date:____/_____/_______

□Body region: __________________________ □ Surgery type: ___________________________________

**17. Do you have any additional information that would be helpful in understanding your problem?**

**Patient signature: ____________________________________________Date: ____________**