# DESCRIPTION OF SYMPTOMS

First Name _____ Last Name _____ Date _____

1. Complaint #1_____

2. How severe is the complaint?
   no pain very severe
   0 1 2 3 4 5 6 7 8 9 10

3. How often do you notice complaint?
   rare constant
   0 1 2 3 4 5 6 7 8 9 10

4. Date complaint began._____

5. How did it start?
   a) Overexertion/Strenuous Position
   b) Auto Accident/Work Accident
   c) Fall /Trip /Slip
   d) Other_____

6. Is this problem
   a) getting better
   b) getting worse
   c) unchanged

7. What makes you feel worse?
   _____
   _____

8. What helps you feel better?
   _____
   _____

9. Describe Pain you may have
   a) Dull ache
   b) Sharp/Stabbing
   c) Burning
   d) Throbbing
   e) Other_____

1. Complaint #2_____

2. How severe is the complaint?
   no pain very severe
   0 1 2 3 4 5 6 7 8 9 10

3. How often do you notice complaint?
   rare constant
   0 1 2 3 4 5 6 7 8 9 10

4. Date complaint began._____

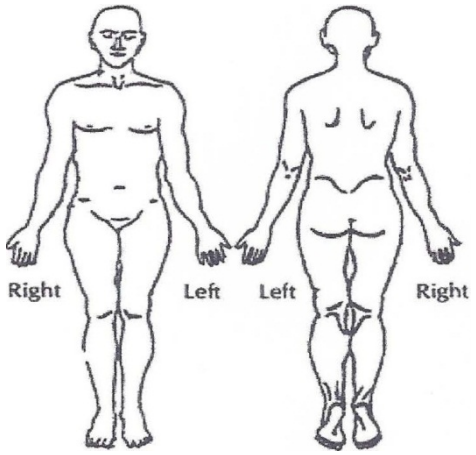
5. How did it start?
   a) Overexertion/Strenuous Position
   b) Auto Accident/Work Accident
   c) Fall / Trip / Slip
   d) Other_____

6. Is this problem
   a) getting better
   b) getting worse
   c) unchanged

7. What makes you feel worse?
   _____
   _____

8. What helps you feel better?
   _____
   _____

9. Describe Pain you may have
   a) Dull ache
   b) Sharp/Stabbing
   c) Burning
   d) Throbbing
   e) Other _____




**Please mark on the drawing to the left the areas where you having a problem.**

**X= Pain**

**S= Stiffness**

**T= Tightness**