BackCare Family Chiropractic
Symptom Survey

Patient Name:_____ Patient Number:_____

1. Condition | Severity (Minimum to Severe) | Frequency (Occasional to Constant)

a._____ 0 1 2 3 4 5 6 7 8 9 10 _____

b._____ 0 1 2 3 4 5 6 7 8 9 10 _____

c._____ 0 1 2 3 4 5 6 7 8 9 10 _____

d._____ 0 1 2 3 4 5 6 7 8 9 10 _____

2. When did your symptoms begin? a._____b. _____

c._____d._____

3. Is there anything that you can do to relieve the symptoms? __No__Yes explain:_____
_____

4. Have you experienced these symptoms before? _____

5. Have your conditions _____Improved _____Gotten Worse _____Stayed the same since it began

6. Circle what makes your problems worse:
Include amount of time before pain INCREASES/STARTS
Sitting_____ Standing_____ Walking_____ Bending_____ Twisting____ Laying____ Lifting_____ Movement_____

7. Describe your symptoms? (circle)
a. Dull / Aching / Sharp / Tingling / Numbness / Burning / Pins & Needles _____
b. Dull / Aching / Sharp / Tingling / Numbness / Burning / Pins & Needles _____
c. Dull / Aching / Sharp / Tingling / Numbness / Burning / Pins & Needles _____
d. Dull / Aching / Sharp / Tingling / Numbness / Burning / Pins & Needles _____

8. Are your symptoms worse in the: (circle)
Morning / Afternoon / Night / Increase or decrease during day / same all day

9. Do your symptoms radiate? _____

10. Is your condition interfering with any daily living activities? (Work, Sleep, Recreation, ect.)_____
_____

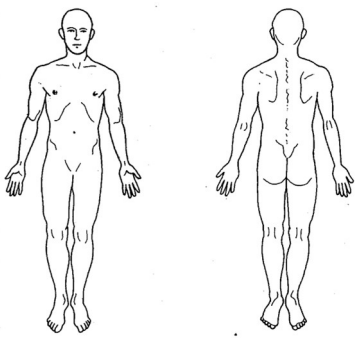
12. Please indicate on the figures where you are experiencing your symptoms.

13. Have you been treated for these before? _____

14. What treatment have you received? _____

15. What are your goals when it comes to treatment at our office?_____
_____

Additional Comments : _____
_____



I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature:_____ Date: _____ Staff Initials: _____