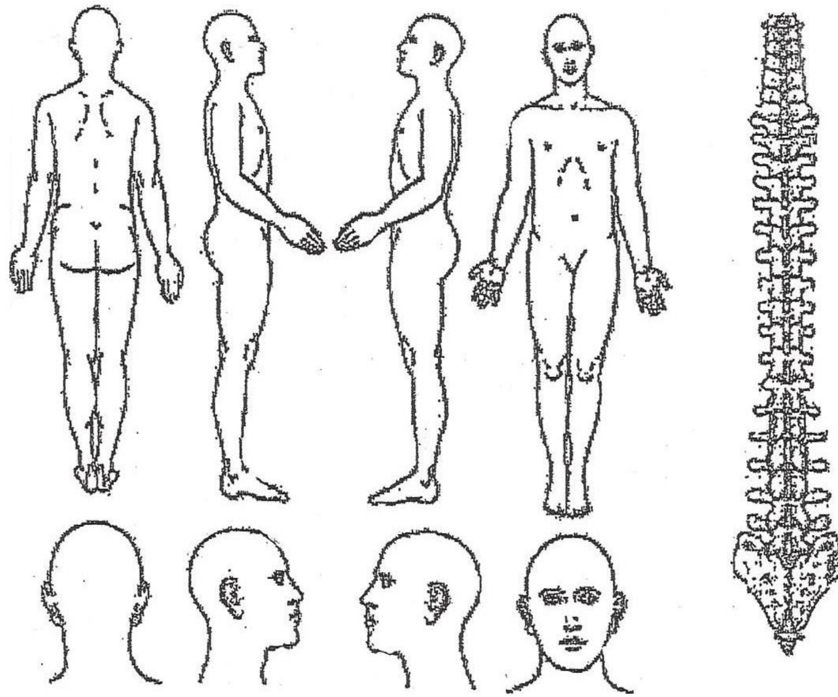
Patient Symptoms Report & Diagram

Name:_______________________________ Age:_______Occupation:______________Date:_________________

Are you still working? ☐ Yes ☐ No Last day on the Job:______________________

Mark these drawings according to where you hurt (ex: if the back of your neck has pain, circle the back of the neck, etc.). Include all affected areas.



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

Now:	No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible
At Worst:	No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible
At Best:	No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain Possible

When (roughly what date) did your present pain start?_____________________________________

How did pain start? (Check appropriate box)

☐ Suddenly ☐ Gradually ☐ Twisting ☐ Bending
☐ Lifting ☐ Fall ☐ Pulling/Pushing ☐ Injured at work
☐ Injured during sports ☐ Injured in Auto Accident ☐ No apparent cause

Have you had similar pain? ☐ Yes ☐ No Date_______________

Have you been hospitalized for your pain problem? ☐ Yes ☐ No Date_______________

What describes the nature of your symptoms?

☐ Sharp ☐ Shooting ☐ Burning
☐ Dull ache ☐ Numb ☐ Tingling