CATALYST CHIROPRACTIC

Additional Symptom Form

Symptom # :

_____

• On a scale of 1 – 10, 10 being the worst pain you've ever felt, what is the severity of your symptom?

1 2 3 4 5 6 7 8 9 10

• What percent of the time do you feel the symptom?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• When did this episode begin? _____

• Did it begin: ☐ Suddenly ☐ Gradually

• Describe how it began_____

_____

• Have you had the symptom in the past before? ☐Yes☐ No

• If yes, when was the first time you've ever felt the symptom:

_____

• What makes the symptom worse?

_____

• What makes the symptom better?

_____

• Does the pain radiate? ☐ Yes ☐ No

• If yes, describe in detail where it radiates

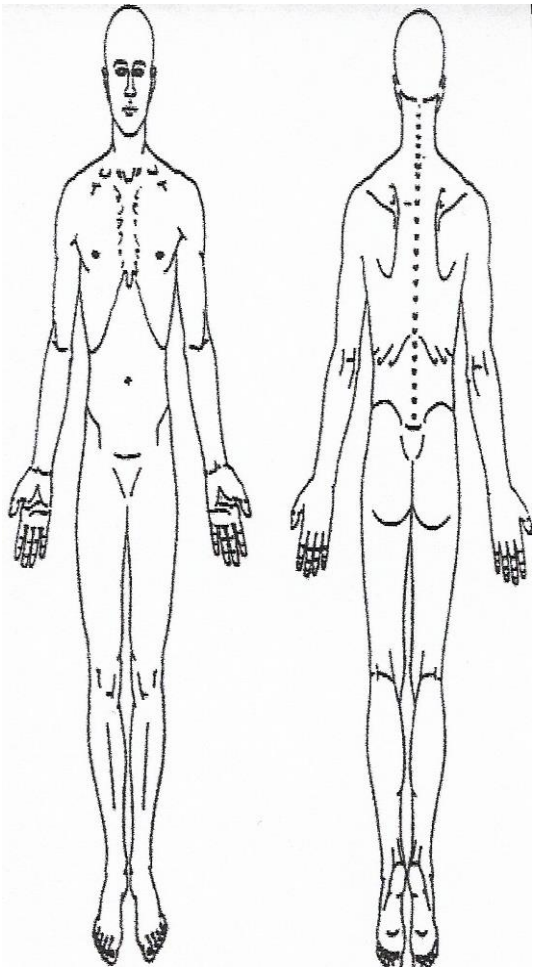
_____

_____

_____

Please mark on the diagram with the following letters to describe your symptoms:

R=Radiating **B**=Burning **D**=Dull **A**=Aching **S**=Sharp/Stabbing **T**=Tingling **N**=Numbness



• Does the pain feel worse at a particular time of day? ☐ Morning ☐ Afternoon ☐ Early evening ☐ Late at night ☐ Unchanged by time of day