Description of Symptoms - Additional Symptoms

Page _____

_____ Current Symptom: (Please check off the boxes below to describe your symptom. Describe only ONE symptom per section)

1. Check only one body location below

❑Headaches L ❑ R ❑ B ❑
- ❑ Front of Head
- ❑ Top of Head
- ❑ Back of Head

	Left	Right	Both
❑ Jaw/TMJ…….	L ❑	R ❑	B ❑
❑ Eye……..	L ❑	R ❑	B ❑
❑ Neck……	L ❑	R ❑	B ❑
❑ Upper Back….	L ❑	R ❑	B ❑
❑ Mid Back…….	L ❑	R ❑	B ❑
❑ Low Back……	L ❑	R ❑	B ❑
❑ Chest……...	L ❑	R ❑	B ❑
❑ Abdomen……	L ❑	R ❑	B ❑
❑ Ribs…….	L ❑	R ❑	B ❑
❑ Buttocks…….	L ❑	R ❑	B ❑
❑ Shoulder…….	L ❑	R ❑	B ❑
❑ Upper Arm…..	L ❑	R ❑	B ❑
❑ Forearm……..	L ❑	R ❑	B ❑
❑ Hand……	L ❑	R ❑	B ❑
❑ Hip……	L ❑	R ❑	B ❑
❑ Leg……...	L ❑	R ❑	B ❑
❑ Foot……	L ❑	R ❑	B ❑
❑ _____	L ❑	R ❑	B ❑
❑ _____	L ❑	R ❑	B ❑

2. Types of Pain (mark each type of pain experienced in this body location)

Other types of pain: _____ _____

- ❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
- ❑ Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
- ❑ Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑ Constricting

3. Pain Frequency

- ❑ Up to 1/4 of awake time ❑ 1/4 to 1/2 of time
- ❑ 1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activities)

- ❑ Doesn't affect ❑ Somewhat affects
- ❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	L ❑	R ❑	B ❑
❑ Neck	L ❑	R ❑	B ❑
❑ Shoulder	L ❑	R ❑	B ❑
❑ Arm	L ❑	R ❑	B ❑
❑ Hand	L ❑	R ❑	B ❑
❑ Hip	L ❑	R ❑	B ❑
❑ Leg	L ❑	R ❑	B ❑
❑ Foot	L ❑	R ❑	B ❑
❑	L ❑	R ❑	B ❑

6. Actions affecting this pain

	Brings on	Aggravates	Relieves
❑ In the AM……	B ❑	A ❑	R ❑
❑ In the PM……	B ❑	A ❑	R ❑
❑ Bending forward…	B ❑	A ❑	R ❑
❑ Bending back……	B ❑	A ❑	R ❑
❑ Bending left……..	B ❑	A ❑	R ❑
❑ Bending right…….	B ❑	A ❑	R ❑
❑ Twisting left…….	B ❑	A ❑	R ❑
❑ Twisting right…….	B ❑	A ❑	R ❑
❑ Coughing……	B ❑	A ❑	R ❑
❑ Sneezing……	B ❑	A ❑	R ❑
❑ Straining……	B ❑	A ❑	R ❑
❑ Standing……	B ❑	A ❑	R ❑
❑ Sitting……	B ❑	A ❑	R ❑
❑ Lifting……	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑

_____ Current Symptom

(Please check off the boxes below to describe you next symptom).

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❑ Foot	L ❑	R ❑	B ❑
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❑ _____	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑
❑ _____	B ❑	A ❑	R ❑