# Symptom Questionnaire

**Name** _____

**Problem #1—Describe your symptoms** _____

**Problem #1—When did it start?** _____

**Problem #1—How did it start?** _____

**Problem #1—How Intense is the pain:**

no pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

**Is Problem #1:** ☐Increasing, ☐Decreasing, or ☐Unchanged since it began

**How often is Problem #1 present?** What percent of the day?

☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)

**How much is Problem #1 interfering with your daily activities:**

not at all (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) cannot function

**Have you ever had previous treatment for Problem #1 ? Circle: Y / N**

**If yes, circle the type: Chiropractic / Physical Therapy / Medications / Massage / Acupuncture**

**Problem #2—Describe your symptoms** _____

**Problem #2—When did it start?** _____

**Problem #2—How did it start?** _____

**Problem #2—How Intense is the pain:**

no pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

**Is Problem #2:** ☐Increasing, ☐Decreasing, or ☐Unchanged since it began

**How often is Problem #2 present?** What percent of the day?

☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)

**How much is Problem #2 interfering with your daily activities:**

not at all (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) cannot function

**Have you ever had previous treatment for Problem #2 ? Circle: Y / N**

**If yes, circle the type: Chiropractic / Physical Therapy / Medications / Massage / Acupuncture**

**Signature** _____ **Date** _____

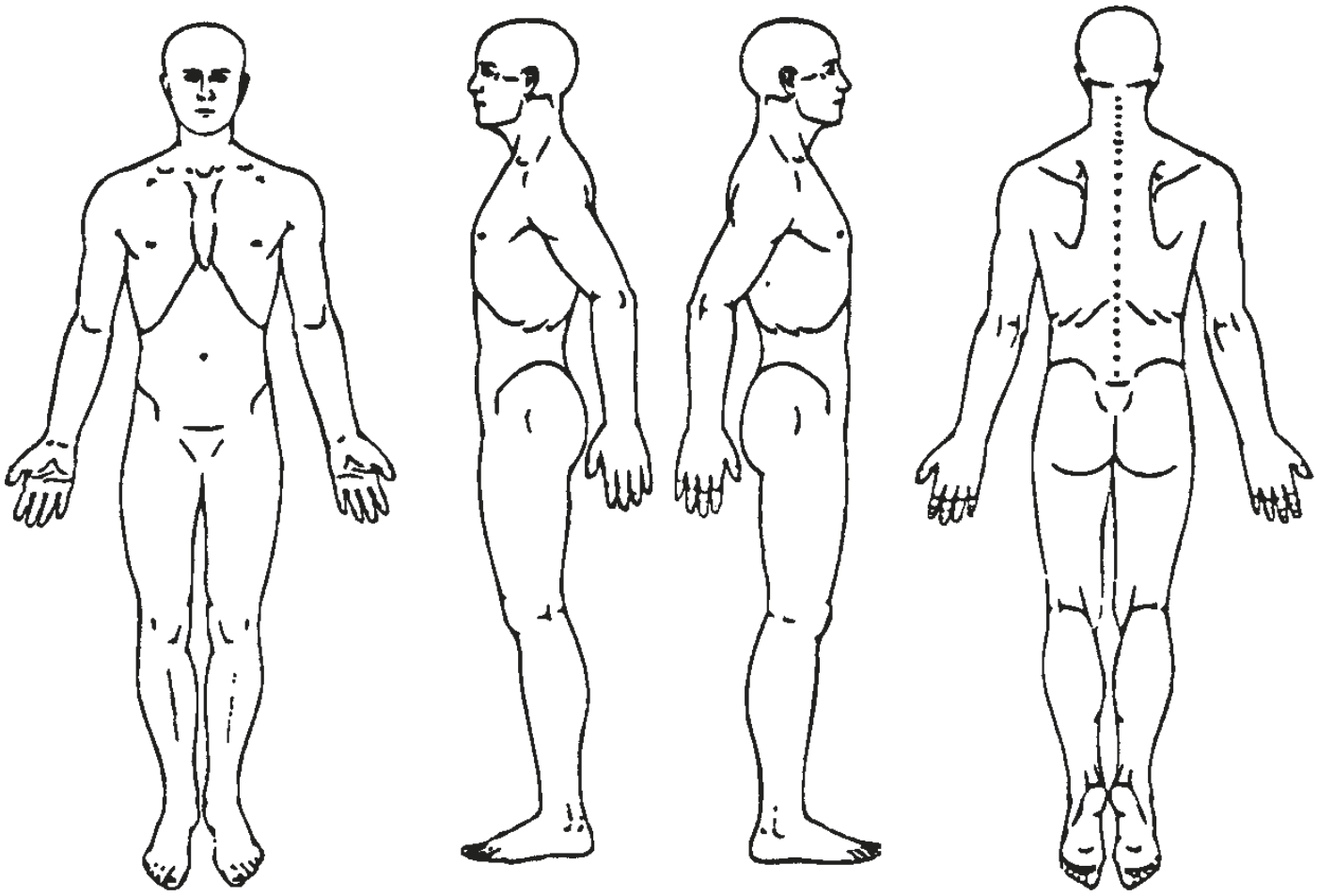
Doctors' Initials

Wiederrich Chiropractic Clinic, APC. 14103 Poway Rd., Poway, CA 92064. (858) 748-4343

## Symptom Drawing

Name: _____

**Please mark where you are having any symptoms. Also indicate whether it is pain, numbness, pins & needles, etc.:**



Signature _____ Date: _____

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