

Symptom Survey
Please circle as many as apply

Patient Name _____ Date _____

Head: Headaches: Mild Moderate Severe How Often (circle)? _____ times per.... Day Week Month

Description of Pain: Sharp Dull Constant Intermittent

Location: Back of Head Forehead Temples Right Side Left Side Behind Eyes

Jaw: Pain: Right Left Both Clicking/Popping: Right Left Both

Neck: Description of Pain: Mild Moderate Severe Locations: Right Side Left Side Both

Are you having any of the following: Stiffness Muscle Spasm Grinding Sounds

Pain Increased by: Fwd Movement Backward Movement Rotate Head Right Rotate Head Left

Bend Head Left Bend Head Right

Upper Upper Arm Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Extremity: Forearm Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Hand Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Mid Back: Pain Location: Right Left Both Pain Level: Mild Moderate Severe

Type of Pain: Sharp Stabbing Dull Muscle Spasms: Right Left Both

Shoulder: Pain Location: Right Left Both Pain Level: Mild Moderate Severe

Type of Pain: Sharp Stabbing Dull

Low Back: Back Pain Level: Mild Moderate Severe

Low Back Pain: Right Left Both Upper Back Pain: Right Left Both

Lower Upper Leg Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Extremity: Lower Leg Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Foot Pain: Right Left Both Numbness: Right Left Both Pins and Needles: Right Left Both

Please list any and all other problems you are having as a result of this injury

Briefly describe how your daily activities have changed due to this injury _____
