SYMPTOM(S) QUESTIONNAIRE

Patient Name _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

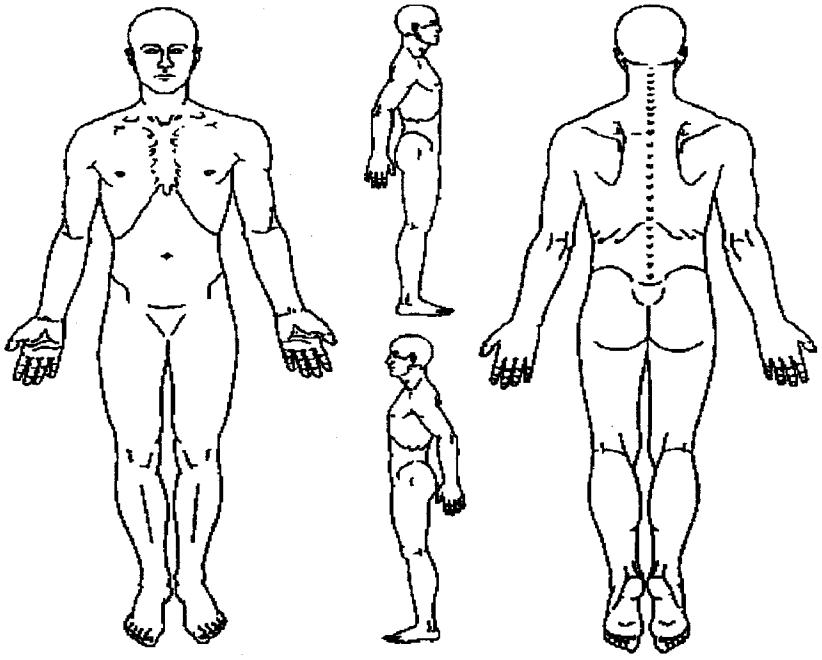
My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



Please tell us how your symptoms are affecting your activities

HOME	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

WORK	No Effect	Mild Effect	Moderate Effect	Severe Effect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

OTHER ACTIVITIES	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sit, Stand, Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend, Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐

Patient Signature _____ Date ____/____/____

Doctor Signature Date ____/____/____