Chiropractic Center of New Britain

Dr. Francis J. Vesci, D.C.

SYMPTOM FORM

Patient Name: _____ ***Date:*** _____

PLEASE READ ME FIRST BEFORE CONTINUING

- **On the following pages you will be asked a series of questions regarding your symptoms/complaints**
- **Use ONE page per symptom if they are separate, AVOID conjoining symptoms.**
- **Start at the top of your body and work your way down, i.e. Headache, Neck Pain, Shoulder Pain, Upper Back Pain, Mid Back Pain, etc.**
- **You are not required to fill out ALL two pages; if you need additional pages, please let the front desk know.**

SYMPTOM 1

Choose only **ONE** symptom

☐**HEAD** ☐**NECK** ☐**SHOULDER** ☐**UPPER BACK**
☐**MID BACK** ☐**LOWER BACK** ☐**HIP** ☐**OTHER**

Briefly describe this symptom/complaint here:

MARK ALL THAT APPLY BELOW FOR THE SYMPTOM YOU CHOSE ABOVE, ON THIS PAGE ONLY

Does this symptom radiate to another part of your body? ☐YES ☐NO

If YES, where does the symptom radiate: _____

When did this symptom begin? Describe here -> _____

How did this symptom begin? Describe here -> _____

☐***SUDDENLY*** ☐***GRADUALLY***

On a scale from 0-10, with 10 being the worst, please circle the number that best describes this symptom MOST of the time:

0 1 2 3 4 5 6 7 8 9 10 (WORST POSSIBLE, i.e. EMERGENCY ROOM)

You experience the above intensity you chose, what percentage (%) of the time you are AWAKE:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 (ALL DAY)

What makes this symptom worse? (mark all that apply)

☐ Bending neck forward ☐ Bending neck backward ☐ Standing ☐ Any movement
☐ Bending forward at waist ☐ Bending backward at waist ☐ Lifting ☐ Nothing
☐ Tilting head left ☐ Tilting head right ☐ Sitting ☐ Getting up from sitting
☐ Turning head left ☐ Turning head right ☐ Driving ☐ Other:
☐ Tilting left at waist ☐ Tilting right at waist ☐ Walking
☐ Twisting left at waist ☐ Twisting right at waist ☐ Running

What makes this symptom feel better? (mark <u>all</u> that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of this symptom (mark <u>all</u> that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

Is this symptom worse at certain times of the day or night? (mark all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

SYMPTOM 2

Choose only **ONE** symptom

☐**HEAD** ☐**NECK** ☐**SHOULDER** ☐**UPPER BACK**
☐**MID BACK** ☐**LOWER BACK** ☐**HIP** ☐**OTHER**

Briefly describe this symptom/complaint here:

MARK ALL THAT APPLY BELOW FOR THE SYMPTOM YOU CHOSE ABOVE, ON THIS PAGE ONLY

Does this symptom radiate to another part of your body? ☐YES ☐NO

If YES, where does the symptom radiate: _____

When did this symptom begin? Describe here -> _____

How did this symptom begin? Describe here -> _____

☐***SUDDENLY*** ☐***GRADUALLY***

On a scale from 0-10, with 10 being the worst, please circle the number that best describes this symptom MOST of the time:

0 1 2 3 4 5 6 7 8 9 10 (WORST POSSIBLE, i.e. EMERGENCY ROOM)

You experience the above intensity you chose, what percentage (%) of the time you are AWAKE:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100 (ALL DAY)

What makes this symptom worse? (mark all that apply)

☐ Bending neck forward
☐ Bending forward at waist
☐ Tilting head left
☐ Turning head left
☐ Tilting left at waist
☐ Twisting left at waist
☐ Bending neck backward
☐ Bending backward at waist
☐ Tilting head right
☐ Turning head right
☐ Tilting right at waist
☐ Twisting right at waist
☐ Standing
☐ Lifting
☐ Sitting
☐ Driving
☐ Walking
☐ Running
☐ Any movement
☐ Nothing
☐ Getting up from sitting
☐ Other:

What makes this symptom feel better? (mark <u>all</u> that apply)

☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Muscle relaxers ☐ Nothing
☐ Other:

Describe the quality of this symptom (mark <u>all</u> that apply)

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Deep Nagging ☐ Shocking
☐ Stinging: ☐ Other:

Is this symptom worse at certain times of the day or night? (mark all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day