Symptom Assessment

Name:___________________________________ Date of Birth: __________________________

Reason for Visit:____

When did your symptoms appear?____

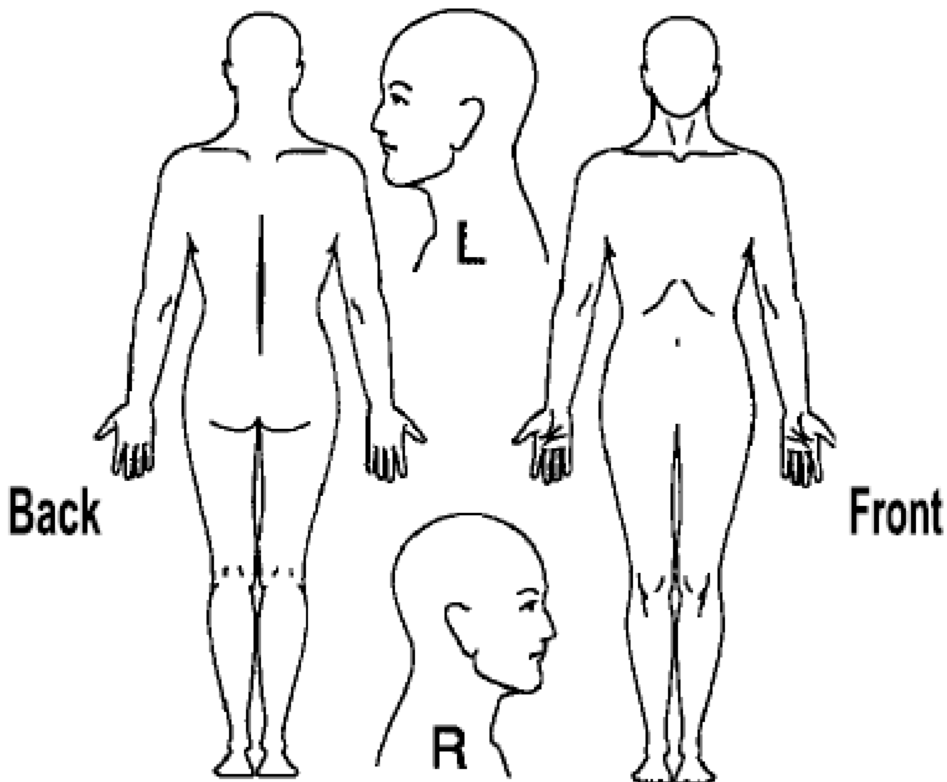
Is this condition getting: ____Worse ___Better ___Staying the same (check one)

At the worst your pain is a ____/10 and at the best your pain is a ___/10 (0 low/10 high)

Is your pain: Constant Intermittent Occasional (circle one)

Mark on this body, using the appropriate symbols. Please mark ALL areas using the described sensations that you feel.

Numbness: **N** Pins & Needles: **P** Burning: **B** Aching: **A** Stabbing: **S** Other: **O**



Place ONE mark on the line below to describe how bad your present pain is:

No Pain I_________I_________I_________I_________I_________I_________I Unbearable Pain