PATIENT NAME _____

DATE _____

CONSULTATION QUESTIONNAIRE

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse ☐
   If yes, when and how? _____
4. How frequent is the condition? Constant ☐ Daily ☐ Intermittent ☐ Night Only ☐
   How long does it last? All Day ☐ Few Hours ☐ Minutes ☐
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes ☐ No ☐. If yes, describe: _____
   Are there other unrelated health problems? Yes ☐ No ☐. If yes, describe _____
   _____
6. Describe the pain: Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐
   Burning ☐ Stabbing ☐ Other _____
7. Is there anything you can do to relieve the problem? Yes ☐ No ☐. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ☐ Sitting ☐ Lying ☐ Bending ☐
   Lifting ☐ Twisting ☐ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes ☐ No ☐ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

Please place an “X” on the line above to indicate level of problem.

Doctor’s Signature _____ Date _____